U.S. Department of Health and Human Services

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

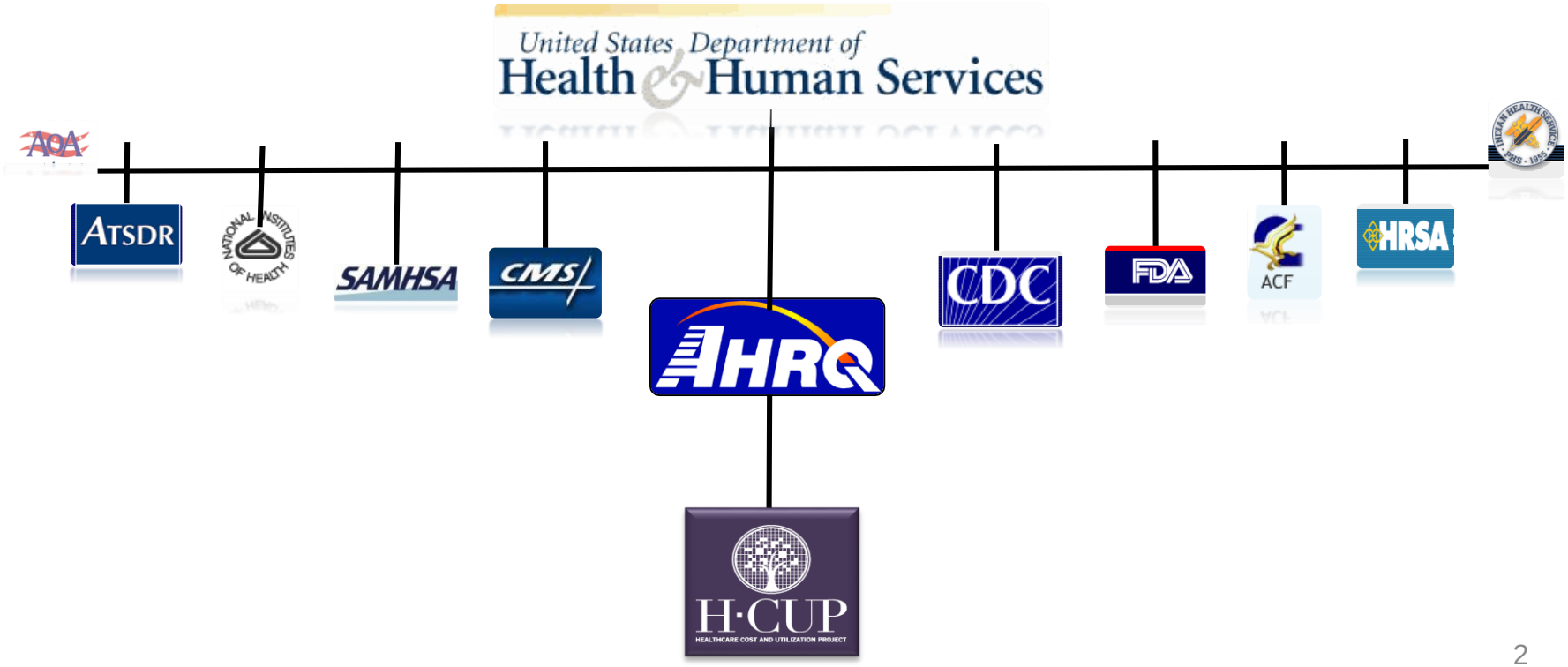
The Healthcare Cost and Utilization Project (HCUP)

Tools and Products to Support Health Services Research and Policy Analysis

Agency for Healthcare Research and Quality Webinar ♦ April 13, 2016

What is the Agency for Healthcare Research and Quality (AHRQ)?

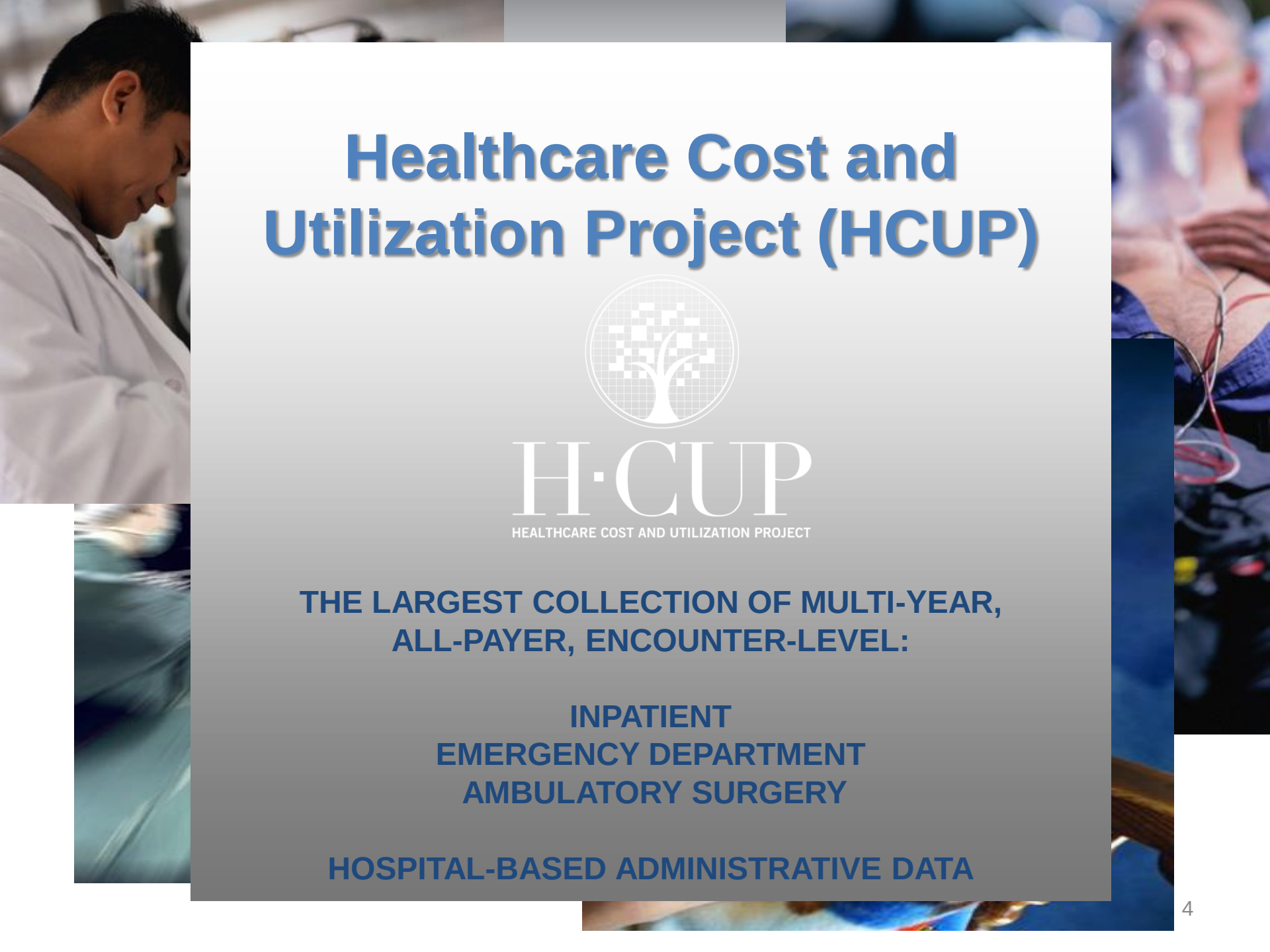
The Agency for Healthcare Research and Quality (AHRQ) is a federal agency under the Department of Health and Human Services.



Webinar Overview

- Brief Database Review
- Tools & Software
- Supplemental Files
- HCUPnet Overview
- HCUP Fast Stats
- Publications and Publication Search
- How to Access HCUP Resources

Healthcare Cost and Utilization Project (HCUP)



H·CUP
HEALTHCARE COST AND UTILIZATION PROJECT

THE LARGEST COLLECTION OF MULTI-YEAR, ALL-PAYER, ENCOUNTER-LEVEL:

INPATIENT
EMERGENCY DEPARTMENT
AMBULATORY SURGERY

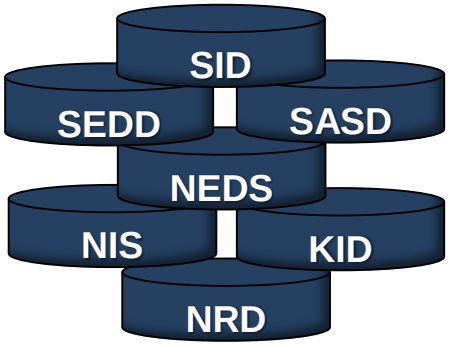
HOSPITAL-BASED ADMINISTRATIVE DATA

What is HCUP?

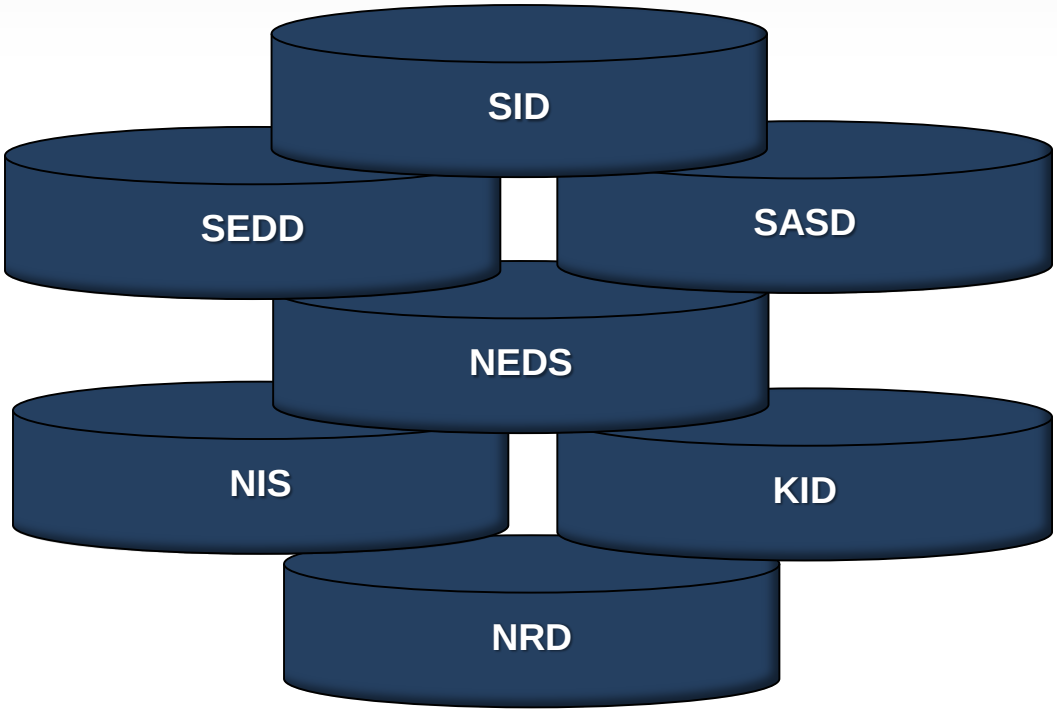
HCUP is a comprehensive set of publicly available all-payer health care data

Includes multi-year inpatient and outpatient data, based on the hospital billing record

- HCUP Databases
- Research Tools
- Research Publications
- User Support



The Core of HCUP: Hospital-Based IP, ED, AS Databases

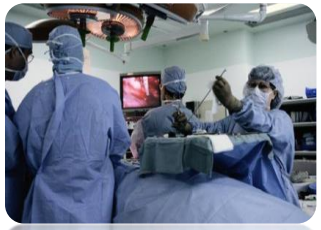


Inpatient, Emergency Department, and Ambulatory Surgery and Services Databases Based on Hospital Billing Data

HCUP has Seven Types of Databases

- Three State-Specific Databases

State Inpatient Databases **(SID)**



State Ambulatory Surgery & Services Databases **(SASD)**

State Emergency Department Databases **(SEDD)**

- Four National (Nationwide) Databases

National Inpatient Sample **(NIS)**

Nationwide Emergency Department Sample **(NEDS)**

Kids' Inpatient Database **(KID)**

Nationwide Readmissions Database **(NRD)**

HCUP State-Specific Databases

State Inpatient Databases (SID)	All inpatient hospital discharge data (including those admissions that started in the ED) from participating HCUP States
State Ambulatory Surgery & Services Databases (SASD)	Ambulatory surgery data (ambulatory surgery and other services from hospital-owned and sometimes nonhospital-owned facilities) from participating HCUP States
State Emergency Department Databases (SEDD)	Emergency department data (treat and release) from participating HCUP States

HCUP National (Nationwide) Databases

National (Nationwide) Inpatient Sample (NIS)	Inpatient discharge data for a **sample of discharges from all hospitals** in SID
Kids' Inpatient Database (KID)	Pediatric inpatient hospital discharge data from a **sample of pediatric discharges** in SID
Nationwide Emergency Department Sample (NEDS)	Emergency department data (treat and release & admitted) from a **sample of hospitals** in SID and SEDD
Nationwide Readmissions Database (NRD)	Inpatient discharge data from **all hospitals for SID with verified patient linkage numbers**

Webinar Overview

- Brief Database Review
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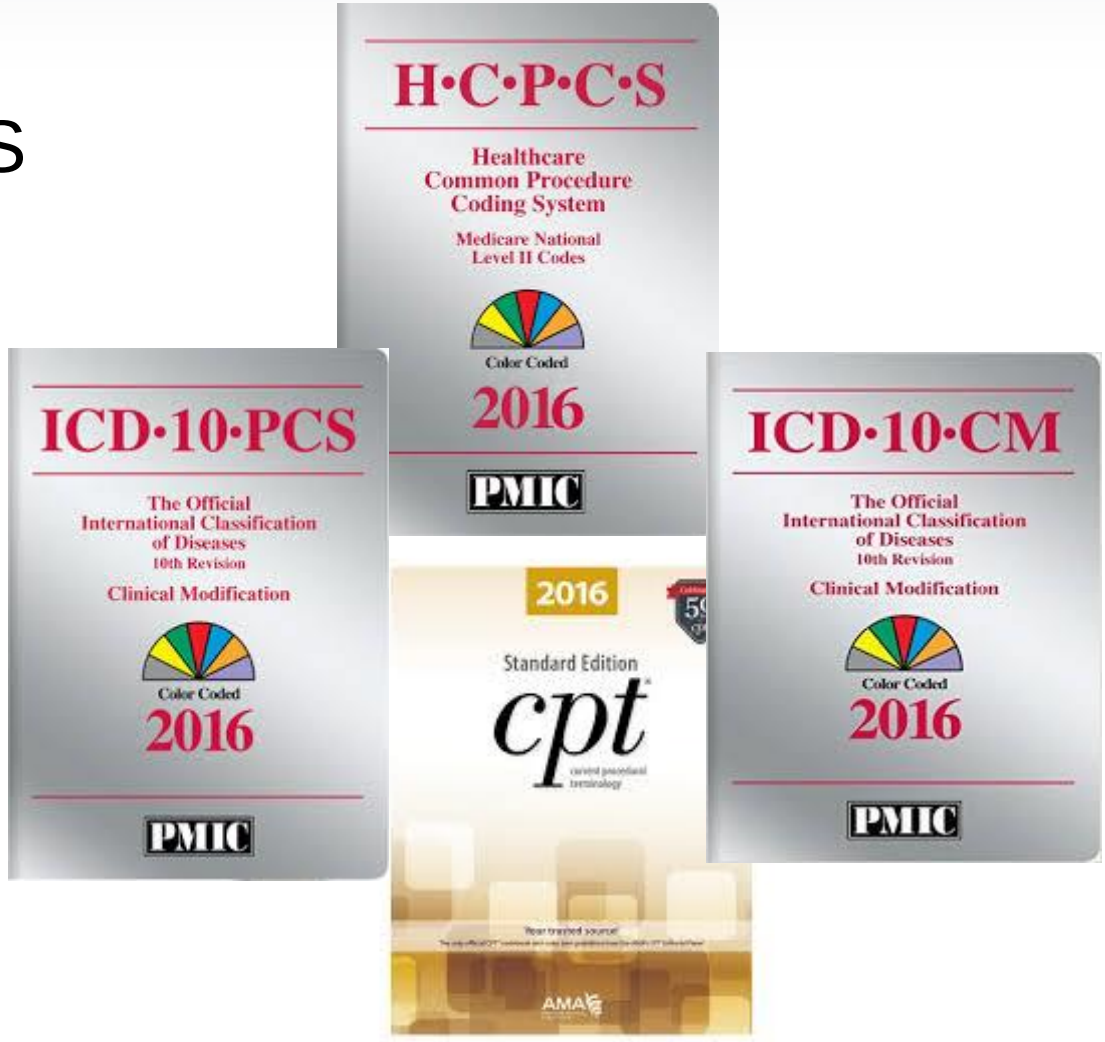
Most HCUP Tools Can be Applied to Any Administrative Database

- Clinical Classifications Software
- Procedure Classes
- Chronic Condition Indicator
- Comorbidity Software
- Utilization Flags
- Surgery Flags
- AHRQ Quality Indicators
  - Prevention Quality Indicators
  - Inpatient Quality Indicators
  - Patient Safety Indicators
  - Pediatric Indicators

Most Tools Based on Medical Coding Classifications

- ICD-9-CM
- ICD-10-CM/PCS
- CPT
- HCPCS
- DRGs
- MDC



Multiple Coding Systems

- ICD-9-CM
- ICD-10-CM/PCS
- CPT
- HCPCS

} Individual Codes

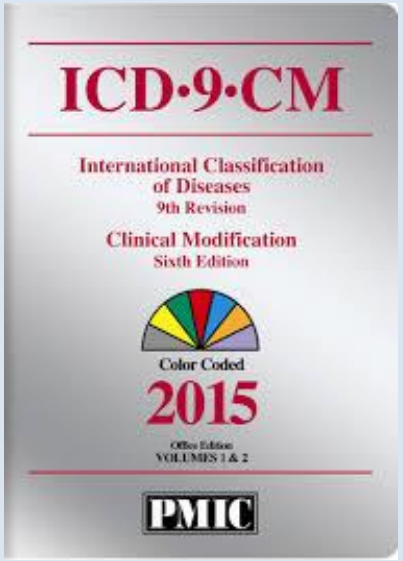
- DRGs
- MDC

} Groupers

Which coding system is appropriate for your analysis?

ICD-9-CM

- **ICD-9-CM Procedure Codes**
- **ICD-9-CM Diagnosis Codes**
- **Included in both inpatient and outpatient databases**



ICD-10-CM/PCS

- **ICD-10-CM**
  - Diagnosis coding under this system uses 3–7 alpha and numeric digits and full code titles
- **ICD-10-PCS**
  - Procedure coding system uses 7 alpha or numeric digits

Common Procedural Coding System – CPT & HCPCS

1. **CPT**
2. **HCPCS**
3. **Local Codes**

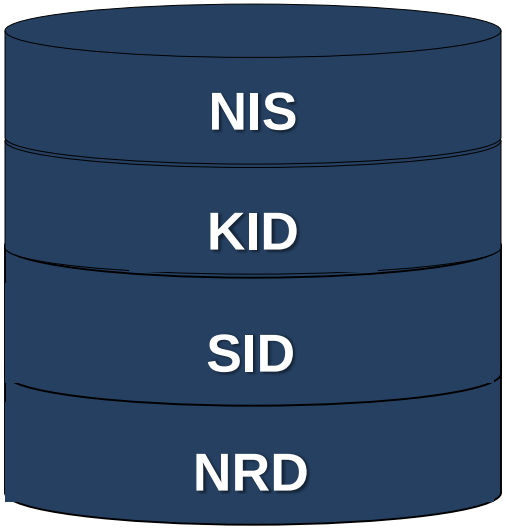
Levels 1 & 2 are included in outpatient (SEDD and SASD) databases

Diagnosis Related Groups (DRGs)

Groups ICD-9-CM and ICD-10-CM Codes into Clinical/Resource Categories using principal diagnosis, secondary diagnoses, surgical procedures, age, gender, and discharge status of the patients treated

DRG Grouper Software

Hospital Administrative Database



Input Variables

- ICD-9-CM Diagnoses and Procedures
- ICD-10-CM Diagnoses
- ICD-10-PCS Procedures
- Age
- Gender
- Discharge Status

DRG Codes

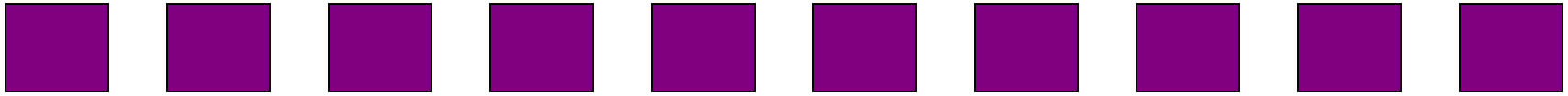
DRG x

DRG x

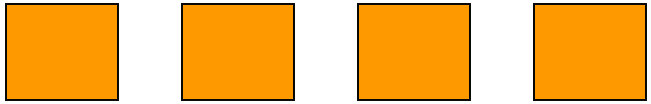
DRG x

DRG x

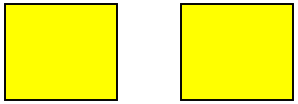
Major Diagnostic Category (MDC)



Over 15,000 ICD-9-CM Codes



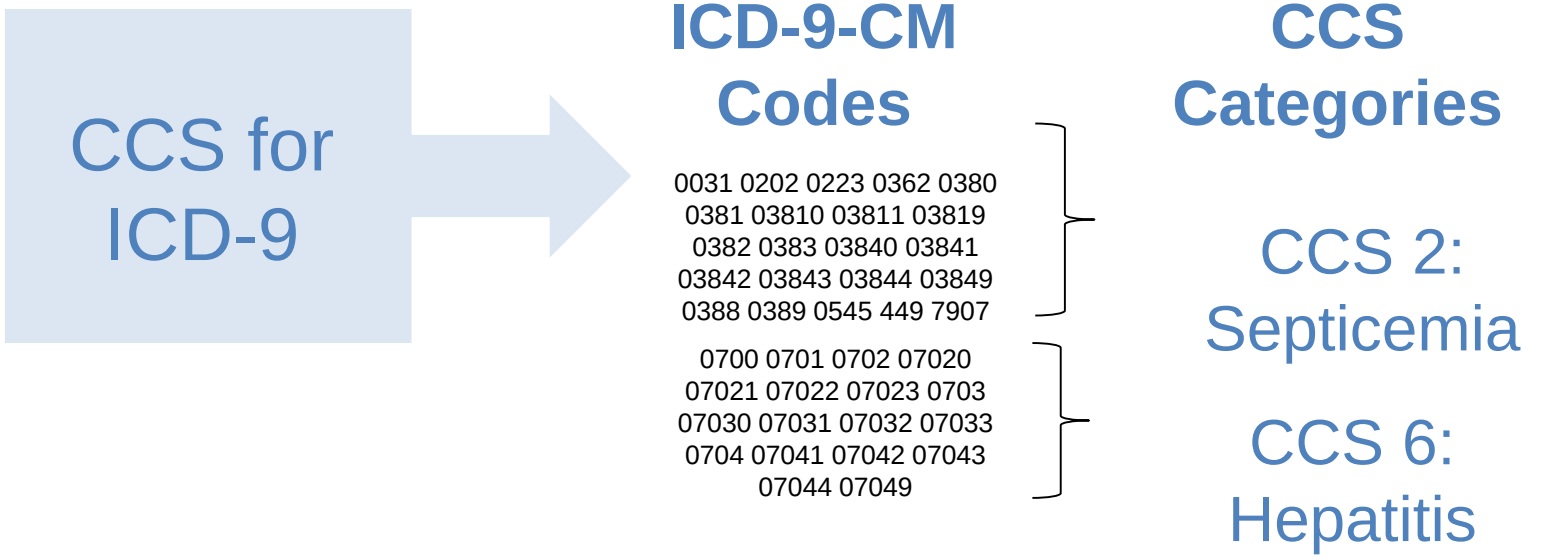
Approximately 500 DRGs



25 MDCs

Clinical Classifications Software (CCS)

- Clusters diagnosis and procedure codes into categories
  - >14,000 diagnoses codes → 285 categories
  - > 4,000 procedure codes → 231 categories
- Useful for presenting descriptive statistics, understanding patterns



Clinical Classifications Software (CCS)

- ICD-9-CM diagnoses and procedures
  - Single-level
  - Multi-level
- ICD-10-CM diagnoses and ICD-10-PCS procedures
  - Single-level
- ICD-10 for mortality
- Services and Procedures
  - Common Procedural Terminology (AMA)

What Codes Are Used in HCUP Data Files?

DETAILED CODES

ICD-9-CM
- Diagnoses Codes
- Procedure Codes

CPT

HCPCS

GROUPED CODES

DRG

MDC

CCS

Inpatient Databases

ICD-9-CM

DRG

MDC

CCS

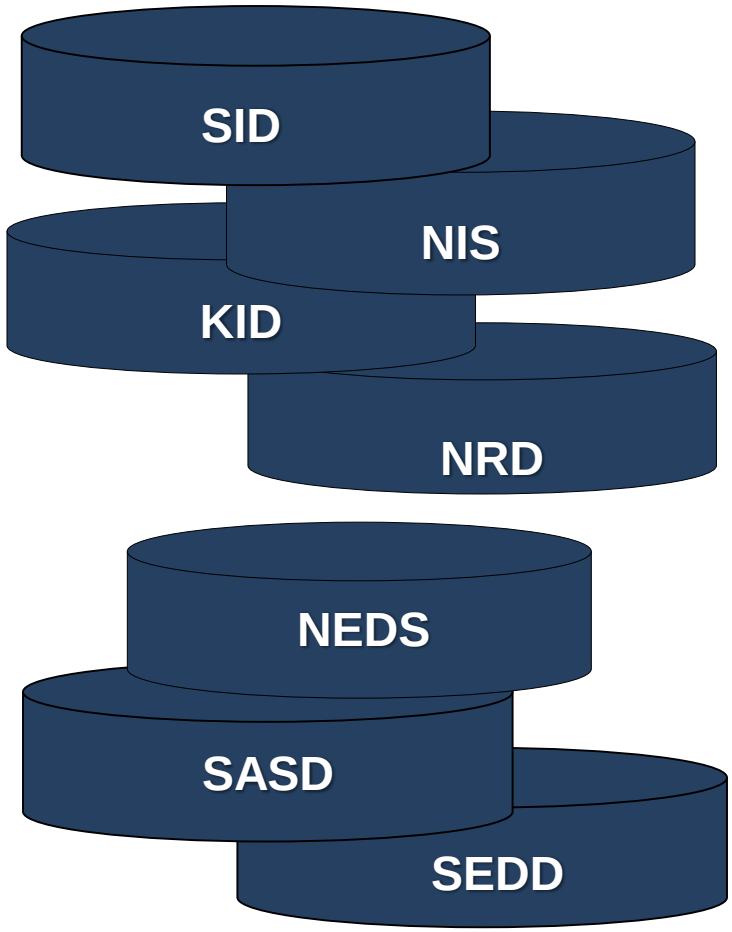
Outpatient Databases

ICD-9-CM

CPT

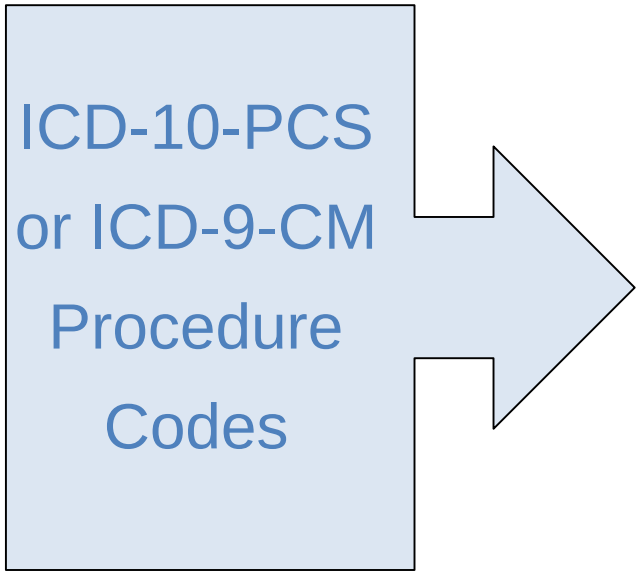
HCPCS

CCS



Procedure Classes

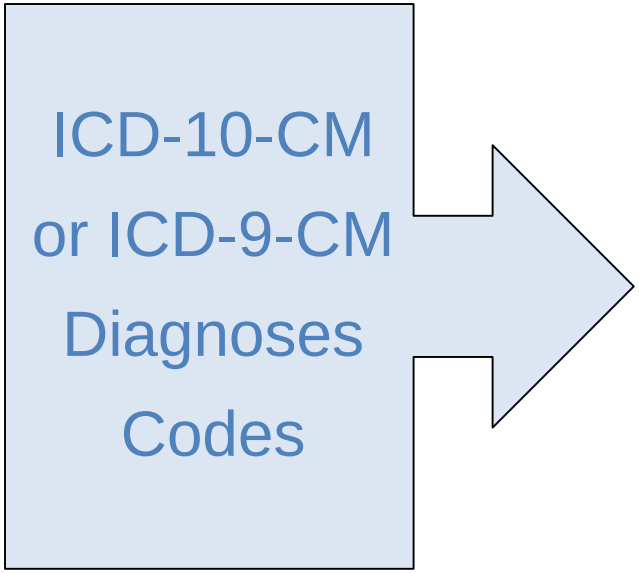
- Groups procedure codes into one of four categories
  - ICD-10-PCS
  - ICD-9-CM procedure codes
- Major procedures defined as OR procedures (DRGs)



1. **Minor Diagnostic**
   Ex: Electrocardiogram
2. **Minor Therapeutic**
   Ex: Pacemaker
3. **Major Diagnostic**
   Ex: Pericardial Biopsy
4. **Major Therapeutic**
   Ex: CABG

Chronic Condition Indicator (CCI)

- Groups diagnosis codes into Chronic or Non-Chronic Categories
  - ICD-10-CM diagnoses codes
  - ICD-9-CM diagnoses codes



- **Chronic**

  Ex: Diabetes

- **Non-Chronic**

  Ex: Food Poisoning

Comorbidity Software

- Creates and appends indicator flags to each record for 29 major comorbidities
  - ICD-10-CM diagnoses codes
  - ICD-9-CM diagnoses codes

ICD-10-CM or ICD-9-CM Codes, DRGs on Administrative Data

Comorbidity Software

29 Comorbidity Groups

Valvular disease
Pulm circ disorders
Peripheral vascular dx
Hypertension
Paralysis
Other neuro disorders
Chronic pulmonary dx
DM w/o complications
DM w/ complications
Hypothyroidism
Renal failure
Liver disease …

Utilization Flags

- Reveals additional information about the use of health care services
- Primarily uses UB-04 revenue codes, augmented with ICD-9-CM procedure codes

Utilization Flag Software

UB-04 codes

+

ICD-9-CM codes

- Emergency Room
- Observation Services/ CT Scan
- Intensive Care Unit

30 Utilization Flags

Utilization Flags	
Accommodation	
Intensive Care Unit (ICU)	Coronary Care Unit (CCU)
Newborn Level II	Newborn Level III
Newborn Level IV	
Cardiac Services	
Cardiac Catheterization Lab	Cardiac Stress Test
Echocardiogram	Electrocardiogram (EKG)
Imaging and Diagnostic Tests	
Computed Tomography (CT) Scan	Chest X-Ray
Electroencephalogram (EEG)	Ultrasound
Magnetic Resonance Technology (MRT)	Nuclear Medicine
Devices	
Pacemaker	Other Implants
Therapeutic Services	
Lithotripsy	Occupational Therapy
Physical Therapy	Respiratory Therapy
Therapeutic Radiology and Chemotherapy	Renal Dialysis
Speech-Language Pathology	Erythropoietin (EPO)
Mental Health and Substance Abuse	Blood

There are not ICD-9-CM codes for all services. Concern exists that some diagnostic procedures may be under-reported.

Surgery Flags

- Identifies encounters for surgical procedures in ICD-9-CM or CPT-based inpatient and ambulatory surgery data

ICD-9-CM or CPT

1. Narrow

- Invasive therapeutic surgical procedure involving incision, excision, manipulation, or suturing of tissue that penetrates or breaks the skin
- Typically requires use of an operating room
- Requires regional anesthesia, general anesthesia, or sedation to control pain

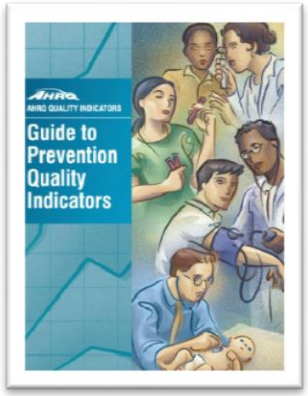
2. Broad

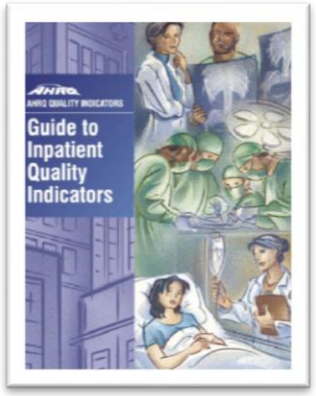
- Includes all narrowly defined surgical procedures as well as a broader group of diagnostic and less invasive therapeutic surgeries

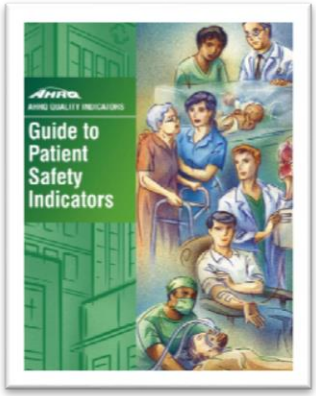
3. Neither Broad nor Narrow

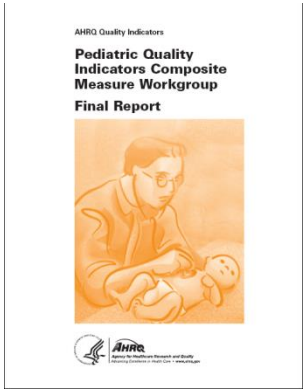
AHRQ Quality Indicators

- Creates measures of health care quality using inpatient administrative data
  - 4 Quality Indicators
    1. Prevention Quality Indicators
    2. Inpatient Quality Indicators
    3. Patient Safety Indicators
    4. Pediatric Indicators



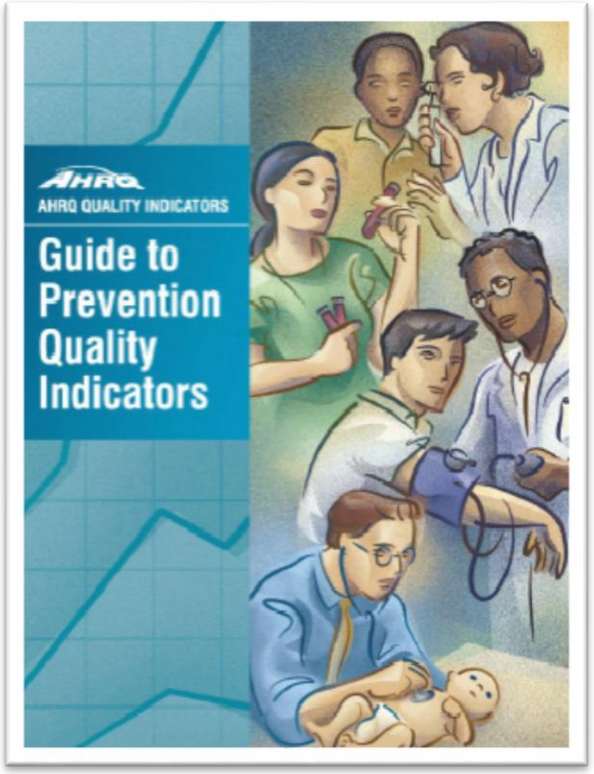






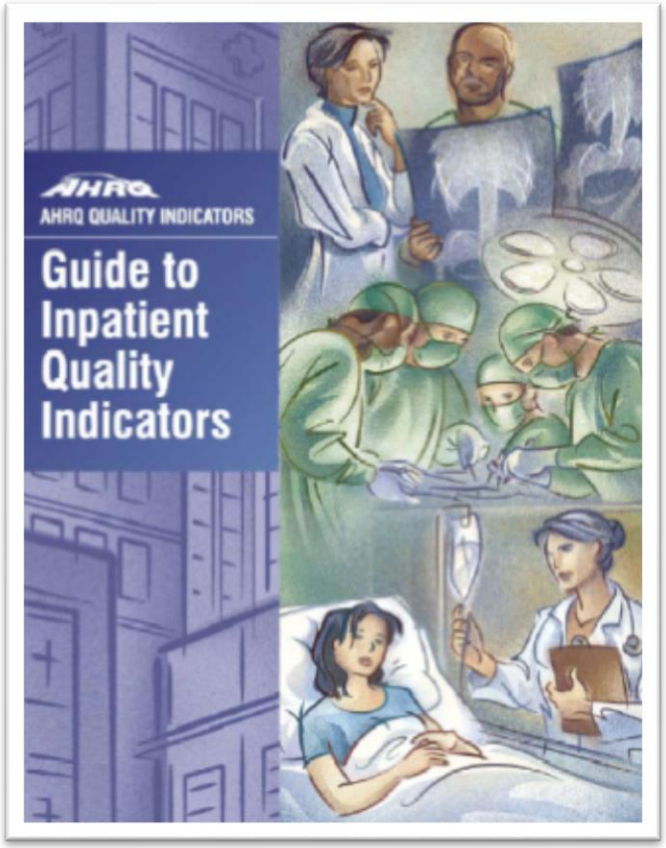
Prevention Quality Indicators (PQIs)

- Identify hospital admissions that are potentially preventable through high-quality outpatient care.
- Examples of PQI Measures:
  - Diabetes Short-term Complication Admission Rate
  - Diabetes Long-term Complication Admission Rate
  - Pediatric Asthma Admission Rate
  - Pediatric Gastroenteritis Admission Rate
  - Hypertension Admission Rate



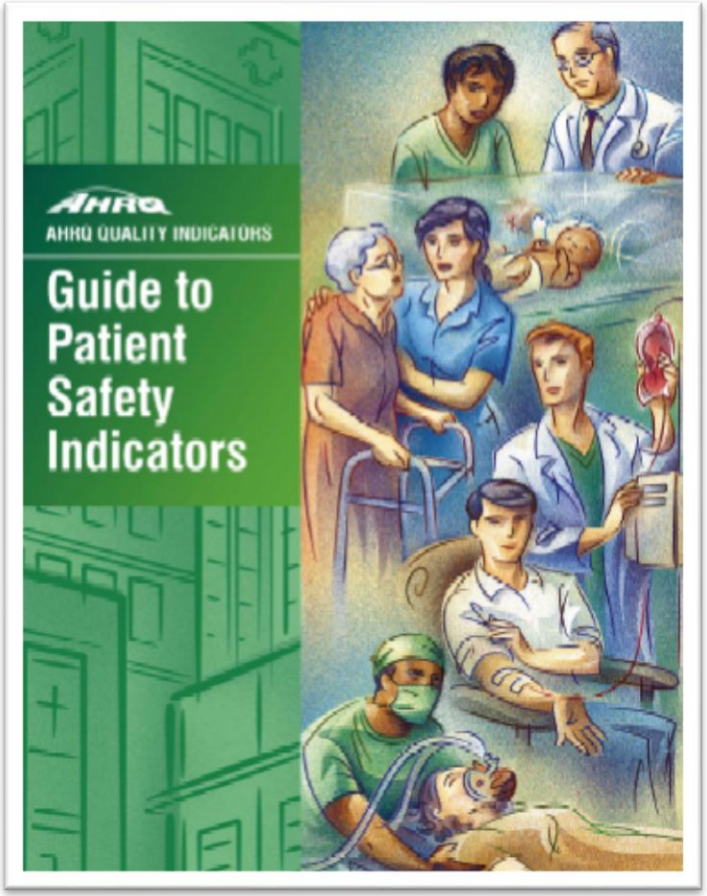
Inpatient Quality Indicators (IQI)

- Reflect quality of care inside hospitals:
  - Inpatient mortality for medical conditions and surgical procedures
  - Utilization of procedures
  - Volume of procedures
- Examples of IQI Measures:
  - Esophageal Resection Volume
  - Pneumonia Mortality Rate
  - Coronary Artery Bypass Graft Mortality Rate
  - Cesarean Section Delivery Rate



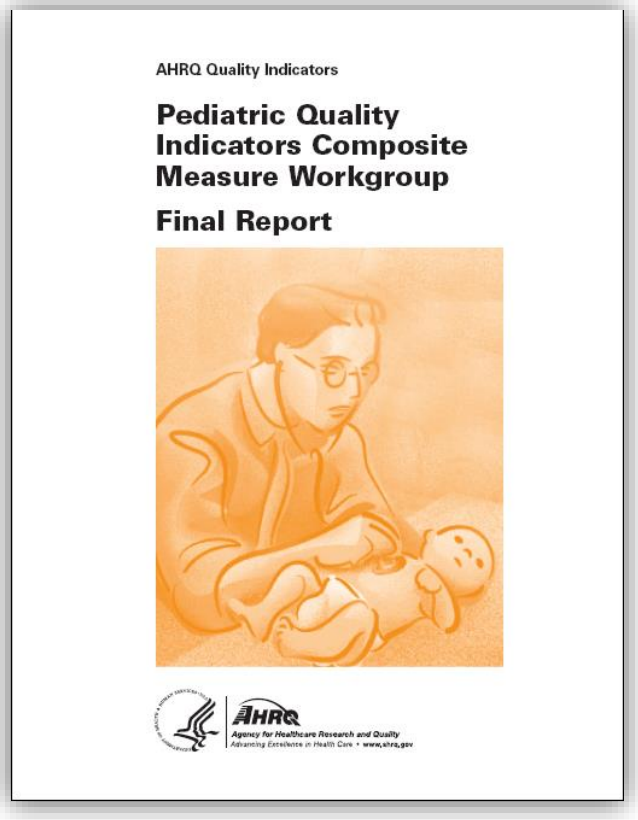
Patient Safety Indicators (PSI)

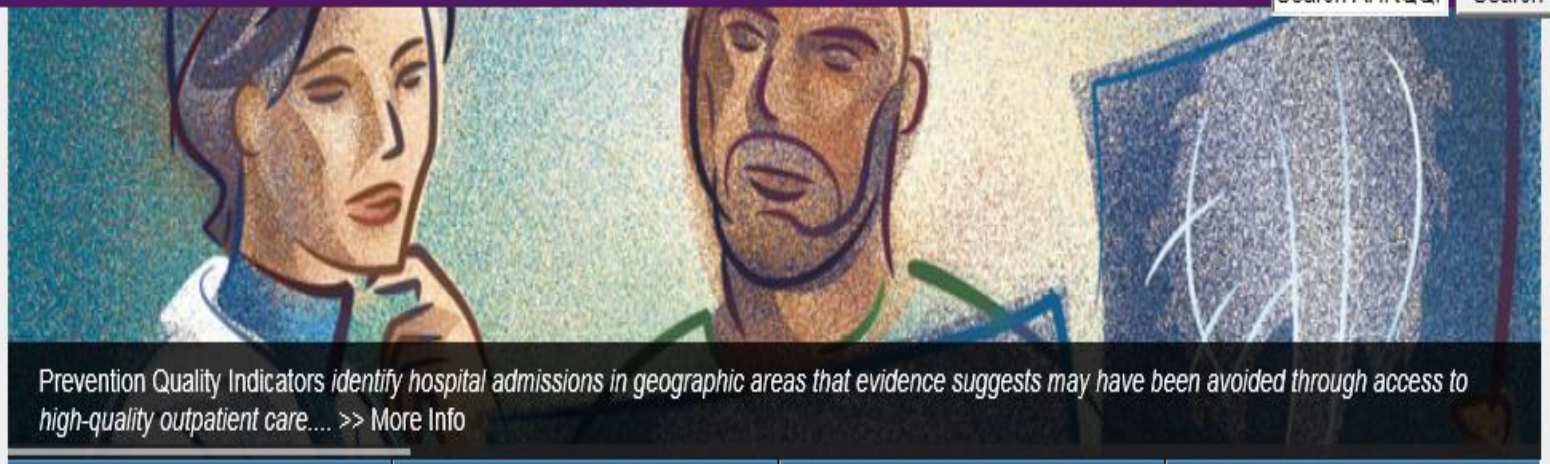
- Identify potentially avoidable complications and iatrogenic events.
- Examples of PSI Measures:
  - Complications of Anesthesia
  - Death in Low-Mortality DRGs
  - Decubitus Ulcer
  - Failure to Rescue
  - Foreign Body Left During Procedure
  - Iatrogenic Pneumothorax



Pediatric Quality Indicators (PDI)

- Identify potentially avoidable hospitalizations among children.
- Examples of PDI Measures:
  - Accidental Puncture or Laceration
  - Decubitus Ulcer
  - Neonatal mortality
  - Pediatric Heart Surgery Mortality
  - Postoperative Hemorrhage or Hematoma





Prevention Quality Indicators *identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care....* >> More Info

Prevention Quality Indicators
>> More Info

Inpatient Quality Indicators
>> More Info

Patient Safety Indicators
>> More Info

Pediatric Quality Indicators
>> More Info

Introduction

The Agency for Healthcare Research and Quality (AHRQ) has developed an array of health care decision making and research tools that can be used by program managers, researchers, and others at the Federal, State and local levels. The Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The current AHRQ QI™ modules expand HCUP QIs. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality: Prevention Quality Indicators, Inpatient Quality Indicators, Patient Safety Indicators, and Pediatric Quality

Email Sign up

Register to receive email of AHRQ announcements and the availability of new quality indicators:

Sign Up: Quality Indicators email updates

News & Announcements

- February 18, 2016 - Software Updates to SAS 5.0 and WinQI 5.0-*New!*
- February 18, 2016 - Request for expert nominations to a Standing Work Group (SWG) for the AHRQ Quality Indicators (QIs) -*Updated! Deadline extended to February 26,2016 for Standing Work Group nominations*

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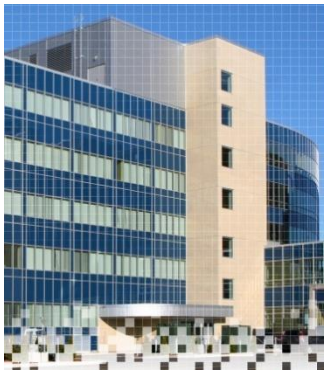
HCUP Supplemental Files Can Only be Applied to HCUP Databases

- **Cost-to-Charge Ratio Files**
- **Hospital Market Structure Files**
- **Supplemental Variables for Revisit Analyses**
- **Trend Weights Files (NIS & KID)**
- **NIS Hospital Ownership File**
- **AHA Linkage Files**

Cost-to-Charge Ratio (CCR) Files

- Enable conversion of charge data to cost data on the NIS, KID, NRD, and SID



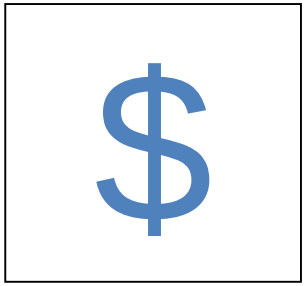
Hospital-Level Data

→

	A	B	C
1	HOSPID	APICC	GAPICC
2	xxxx	xxxx	xxxx
3	xxxx	xxxx	xxxx
4	xxxx	xxxx	xxxx
5	xxxx	xxxx	xxxx
6	xxxx	xxxx	xxxx
7	xxxx	xxxx	xxxx

Apply Ratios

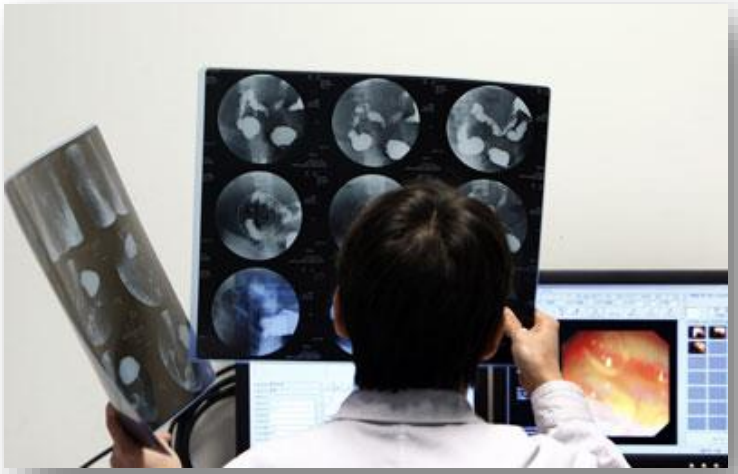
→



Convert Total Charges to Costs

Hospital Market Structure (HMS) Files

- Contain various measures of hospital market competition
- Allow users to broadly characterize the intensity of competition that hospitals face
  - Using various definitions of market area



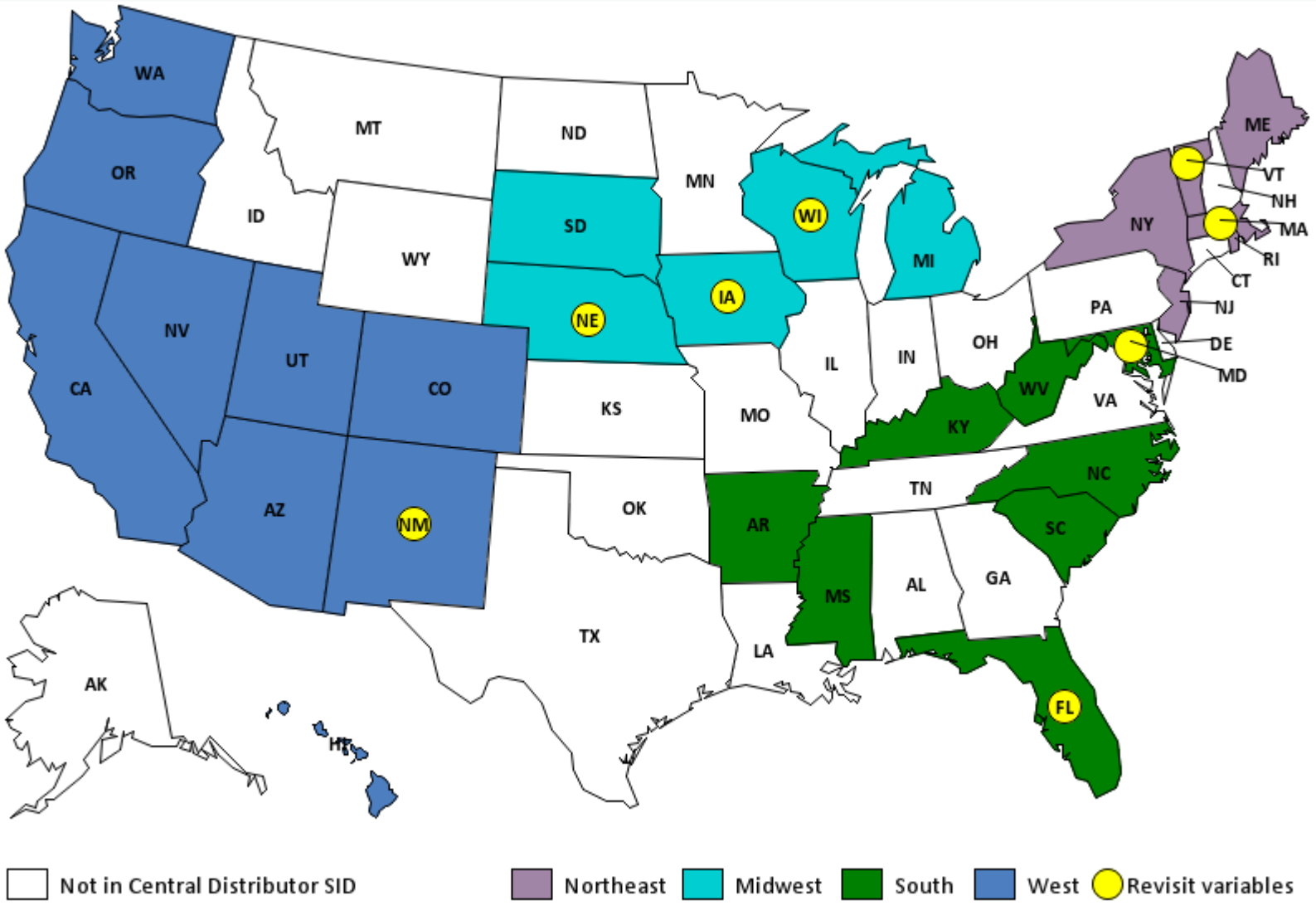
HCUP Supplemental Variables for Revisit Analyses

- Allows linkage across settings and time
  - Hospital readmissions
  - ED visits following hospital discharge
  - Inpatient hospitalizations following ambulatory surgery visits
- Adheres to strict privacy guidelines

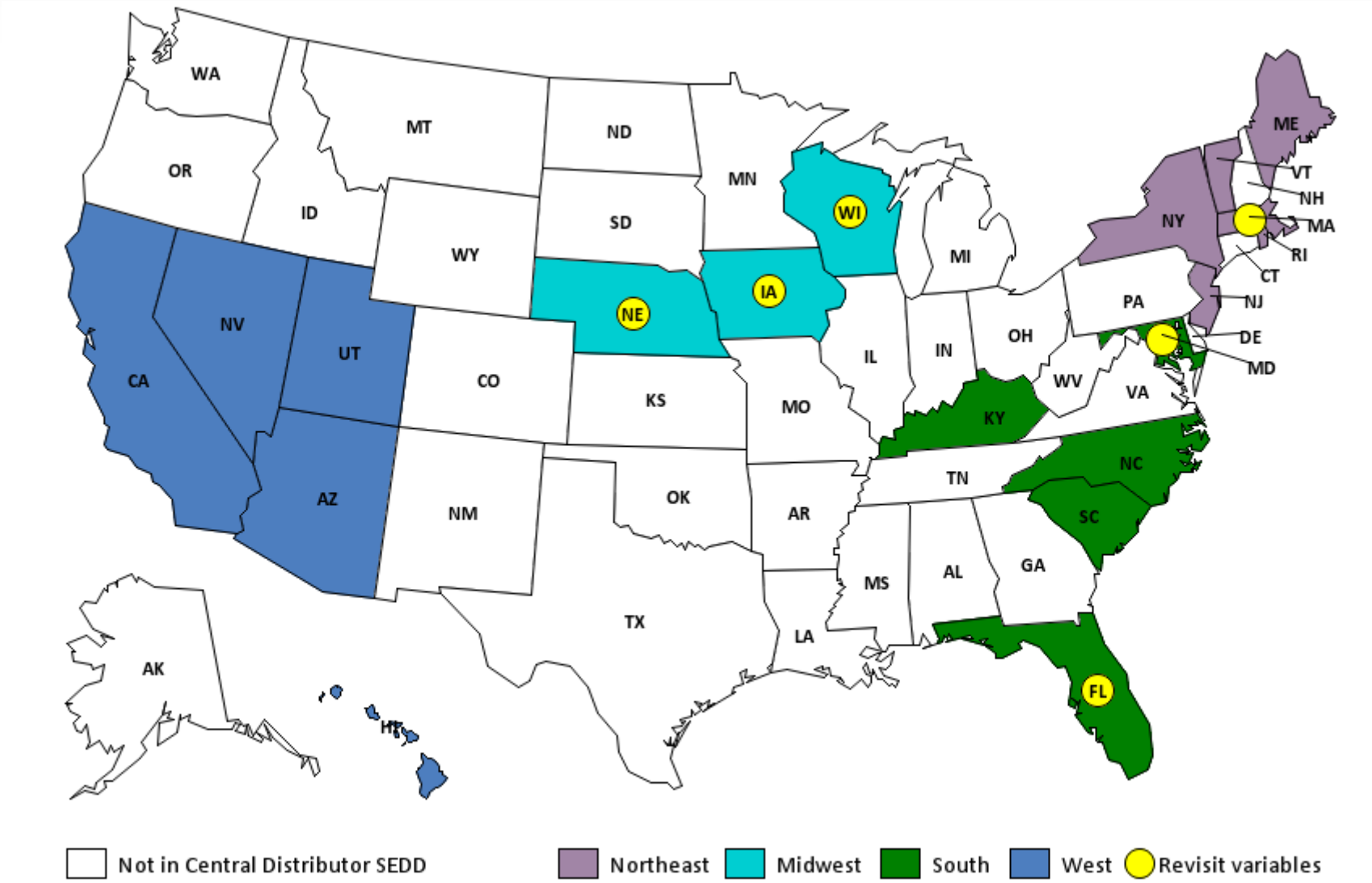
HCUP Supplemental Variables for Revisit Analyses

- There are two HCUP supplemental variables:
  1. Synthetic person-level identifiers
     - Verified against the patient's date of birth and gender
     - Examined for completeness (VisitLink)
  2. Timing variable determines the number of days between events for an individual (DaysToEvent)
     - Without the use of actual dates
- HCUP revisit variables can be used only with the SID, SASD, and SEDD (not nationwide databases) for States with encrypted patient identifiers
- National revisit statistics are available on HCUPnet

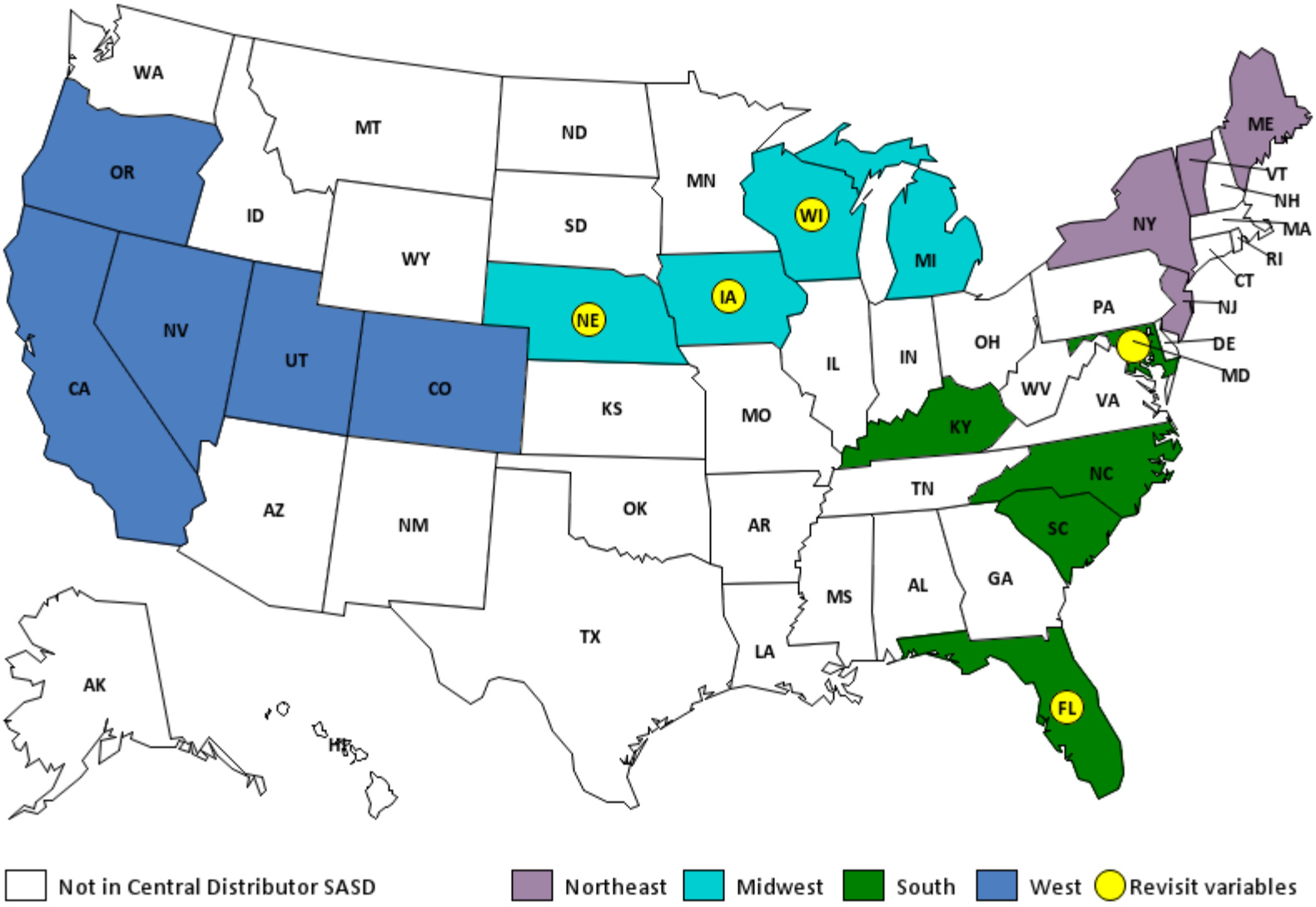
2014 SID States with Revisit Variables



2014 SEDD States with Revisit Variables



2014 SASD States with Revisit Variables



Additional HCUP Supplemental Files

- **Trend Weights Files (NIS & KID)**
  - Discharge-level files that provide trend weights and data elements that are consistently defined across data years
- **NIS Hospital Ownership File**
  - Hospital-level files facilitate analysis of the NIS by hospital ownership categories
- **AHA Linkage Files**
  - Enable researchers to link hospital identifiers in some State databases to the AHA Annual Survey Databases

http://www.hcup-us.ahrq.gov/tools_software.jsp

Favorites

HCUPnet
HCUPnet is an interactive tool for identifying, tracking, analyzing, and comparing statistics on hospital and emergency care. HCUPnet provides statistics from the HCUP Nationwide Databases (NIS, KID, NEDS, and NRD) and the State Databases (SID, SASD, and SEDD) for those States that have agreed to participate.

MONAHRQ
MONAHRQ is a software product that enables organizations - such as state and local data organizations, Chartered Value Exchanges, hospital systems, and health plans - to input their own hospital administrative data and generate a data-driven Web site.

AHRQ Quality Indicators (QIs)
AHRQ Quality Indicators (QIs) use hospital administrative data to highlight potential quality concerns, identify areas that further study and investigation, and track changes over time.

HCUP Tools & Software

The HCUP Tools and Software are analytic methods that, when applied to HCUP databases, systematically create new data elements from existing data, thereby enhancing a researcher's ability to conduct analyses. While designed to be used with H databases, they may be applied to other administrative databases as well.

Tools for ICD-9-CM

ICD-9-CM codes were frozen in preparation for ICD-10 implementation and regular maintenance of the codes has been suspended. The HCUP Tools for ICD-9-CM should only be used with data for discharges before 10/1/2015.

Clinical Classifications Software (CCS) for ICD-9-CM
Clinical Classifications Software (CCS) provides a method for classifying ICD-9-CM diagnoses or procedures into clinically meaningful categories, which can be used for aggregate statistical reporting of a variety of types. (Updated for codes valid through FY 2015.)

Chronic Condition Indicator
The Chronic Condition Indicator (CCI) provides users an easy way to categorize ICD-9-CM diagnosis codes into one of two categories: chronic or not chronic. The tool can also assign ICD-9-CM diagnosis codes into 1 of 18 body system categories. (Codes valid through FY 2015.)

Comorbidity Software
Comorbidity Software assigns variables that identify coexisting conditions on hospital discharge records. (Codes valid through FY 2015.)

Procedure Classes
Procedure Classes facilitate research on hospital services using administrative data by identifying whether a procedure is (a) diagnostic or therapeutic, and (b) minor or major in terms of invasiveness and/or resource use. (Updated for codes valid through FY 2015.)

CPT Based Tools

Surgery Flags
Surgery Flags identify surgical procedures and encounters in ICD-9-CM or CPT-based inpatient and ambulatory surgery data. Two types of surgical categories are identified: NARROW surgery is based on a narrow, targeted, and restrictive definition and includes invasive surgical procedures. BROAD surgery includes procedures that fall under the NARROW category but adds less invasive therapeutic and diagnostic procedures that may are often performed in surgical settings. Users must agree to a license to use the Surgery Flags before accessing the software. (Updated for codes valid through 2015.)

Clinical Classifications Software for Services and Procedures
CCS-Services and Procedures provides a method for classifying Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes into clinically meaningful procedure categories. The procedure categories

Tools for ICD-10-CM/PCS

HCUP tools have be translated to ICD-10-CM/PCS in anticipation of conversion to the new coding system on October 1, 2 We welcome comments. If you have questions or suggestions for changes, please contact hcup@ahrq.gov.

Clinical Classifications Software (CCS) for ICD-10-CM/PCS
Clinical Classifications Software (CCS) for ICD-10-CM/PCS provides a method for classifying ICD-10-CM diagnoses or ICD PCS procedures into clinically meaningful categories, which can be used for aggregate statistical reporting of a variety of types. (Updated for codes valid through FY 2016.)

Chronic Condition Indicator for ICD-10-CM
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Other Tools

Clinical Classifications Software (CCS) for Mortality Reporting
Clinical Classifications Software (CCS) for mortality reporting provides a method for classifying ICD-10 mortality diagnos clinically meaningful categories, which can be used for aggregate statistical reporting of a variety of types. Note that this original ICD-10 system for mortality reporting; not ICD-10-CM/PCS coding *which will be implemented on October 1, 201* Codes are valid through 2009.

Utilization Flags
Utilization Flags reveal additional information about use of health care services by combining information from UB-04 rev

Webinar Overview

- Brief Database Review
- Tools & Software
- Supplemental Files
- HCUPnet Overview
- HCUP Fast Stats
- Publications and Publication Search
- How to Access HCUP Resources

HCUPnet: Quick, Free Access to HCUP Data

- Free, interactive online query system
- Users generate tables of outcomes by diagnoses and procedures
- Data can be cross-classified by patient and hospital characteristics

http://hcupnet.ahrq.gov/

HCUPnet Can Answer a Variety of Questions

- What percentage of hospitalizations for children are uninsured, by State?
- What are the most expensive conditions treated in U.S. hospitals?
- What is the trend in admissions for depression?
- Will there be a sufficient number of cases to do my analysis?
- How do my estimates and calculations compare with HCUPnet (validation)?

HCUPnet Provides …

- Step-by-step queries on:
  - Hospital inpatient (NIS, KID, SID)
  - ED visits (NEDS, SEDD)
  - Ambulatory surgeries
  - National and regional statistics
- Specialized queries:
  - Mental health related stays
  - Stays by expected payer
  - Hospital-level statistics
- Ready-to-use:
  - National benchmarks for healthcare quality indicators based on the AHRQ Quality Indicators
  - “Quick national or State statistics”
  - Readmissions
  - Community-level statistics

How does HCUPnet Work?

- Step 1: Select the focus of your query.
- Step 2: Select the type of query want.
- Step 3: Select the Outcomes and Measures.
- Step 4: Select patient and hospital characteristics.
- Step 5: Results.

Welcome to H·CUPnet

HCUPnet is a free, on-line query system based on data from the Healthcare Cost and Utilization Project (HCUP). It provides access to health statistics and information on hospital inpatient and emergency department utilization.

HEALTH DATA ALL-STAR

http://hcupnet.ahrq.gov

Begin your query here -

Statistics on Hospital Stays

National Statistics on All Stays

Create your own statistics for national and regional estimates on hospital use for all patients from the HCUP National (Nationwide) Inpatient Sample (NIS). Overview of the National (Nationwide) Inpatient Sample (NIS)

National Statistics on Children

Create your own statistics for national estimates on use of hospitals by children (age 0-17 years) from the HCUP Kids' Inpatient Database (KID). Overview of the Kids' Inpatient Database (KID)

National Statistics on Mental Health Hospitalizations

Interested in acute care hospital stays for mental health and substance abuse? Create your own national statistics from the NIS.

National and State Statistics on Hospital Stays by Payer - Medicare, Medicaid, Private, Uninsured

Interested in hospital stays billed to a specific payer? Create your own statistics for a payer, alone or compared to other payers from the NIS, KID, and SID.

State Statistics on All Stays

Create your own statistics on stays in hospitals for participating States from the HCUP State Inpatient Databases (SID). Overview of the State Inpatient Databases (SID)

Quick National or State Statistics

Ready-to-use tables on commonly requested information from the HCUP National (Nationwide) Inpatient Sample (NIS), the HCUP Kids' Inpatient Database (KID), or the HCUP State Inpatient Databases (SID).

Hospital Readmissions

Readmission Summary Tables

Ready-to-use information on readmissions to the hospital within 30 days of discharge.

Quick Statistics on Readmissions

Sortable tables that provide instant information on 30-day readmissions to the hospital.

Statistics on Ambulatory Surgery Use

Statistics on Ambulatory Surgery

Create your own statistics on ambulatory surgeries for participating States from the HCUP State Ambulatory Surgery and Services Databases (SASD). Compare to statistics on inpatient surgeries for participating States from the HCUP State Inpatient Databases (SID).
Overview of the State Ambulatory Surgery and Services Databases (SASD) Overview of the State Inpatient Databases (SID)

Quick Statistics on Ambulatory Surgery

Ready-to-use tables on commonly requested information from the SASD.

Statistics on Emergency Department Use

National Statistics on All ED Visits

Create your own statistics for national and regional estimates on emergency department visits for all patients from the HCUP Nationwide Emergency Department Sample (NEDS).
Overview of the Nationwide Emergency Department Sample (NEDS)

Quick National or State Statistics on All ED Visits

Ready-to-use tables on commonly requested information from the NEDS, SEDD, and SID.

State Statistics on All ED Visits

Create your own statistics on emergency department visits for participating States from the HCUP State Emergency Department Databases (SEDD) and the SID.
Overview of the State Emergency Department Databases (SEDD)
Overview of the State Inpatient Databases (SID)

First Time Visitor?

- HCUPnet overview
- How does HCUPnet work?
- HCUPnet methodology?
- HCUPnet definitions?

What's New?

- 2013 nationwide Just Add ED data -- new database jus released. (12/11/2015)
- Cost information Just Add for participating states in 20 (10/13/2015)
- 2013 nationwide Just Add hospital data now available. (10/08/2015)
- New 2013 readmission data added. (09/30/2015)
- Maps are now available on t Community-Level Statistics path. (06/08/2015)
- 2013 data for participating States. (04/09/2015)
- All NIS results Important No prior to 2012 recalculated to permit trend analysis

Projected estimates on specif conditions are periodically available here.

H·CUP

More information HCUP data, too and reports

What is HCUP?

Brief description - what is HCUP

Want to purchase data to do yo own analysis?

The statistics in HCUPnet would not be possible without partner organizations that provide da to HCUP.

HCUPnet is based on aggregate statistics t to speed up data transfer and protect indiv records, so not all possible queries can be addressed. If a query is not possible, HCU will not allow you to choose certain param If there is a query you'd like to see that HCUPnet does not support, please write us hcup@ahrq.hhs.gov. Internet Citation: HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research a Quality, Rockville, MD. http://hcupnet.ahrq.gov/

HCUPnet Capabilities

HCUPnet...	
CAN PRODUCE...	**CANNOT PRODUCE…**
Simple statistics	More complicated queries
Sample size calculations	Multivariate analyses
Trends information	Statistics involving certain variables
Rank ordering of diagnoses and procedures	Statistics that may violate confidentiality (patient-, provider-, hospital-level data)
Significance testing	

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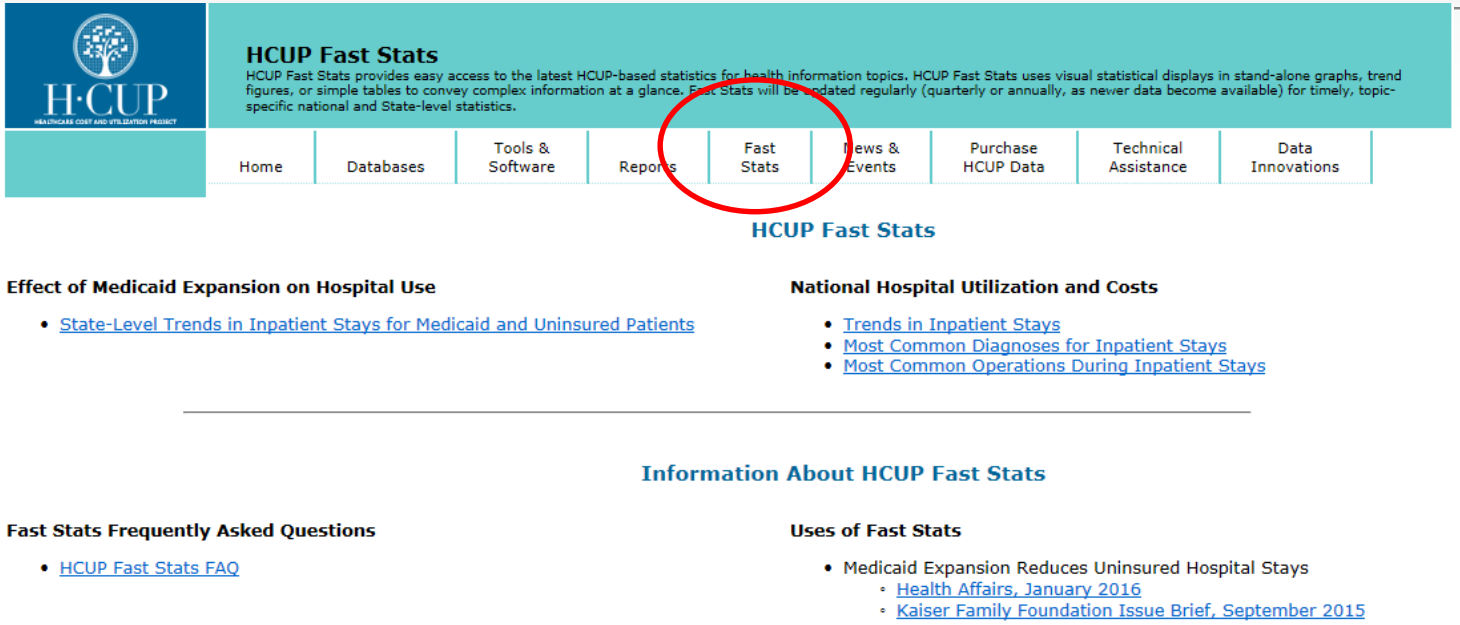
HCUP Fast Stats



- HCUP Fast Stats provides easy access to the latest HCUP-based statistics for health information topics.
- Uses visual statistical displays in stand-alone graphs, trend figures, or simple tables to convey complex information at a glance.
- Information will be updated regularly (quarterly or annually, as newer data become available).

http://www.hcup-us.ahrq.gov/faststats/landing.jsp

HCUP Fast Stats – *Effect of Medicaid Expansion on Hospital Use*

HCUP Fast Stats - Effect of Medicaid Expansion on Hospital Use

HCUP Fast Stats provides easy access to the latest HCUP-based statistics for health information topics. Information on the effect of Medicaid expansion on hospital use will be updated regularly (quarterly or annually, as newer data become available).

Home | Databases | Tools & Software | Reports | Fast Stats | News & Events | Purchase HCUP Data | Technical Assistance | Data Innovations

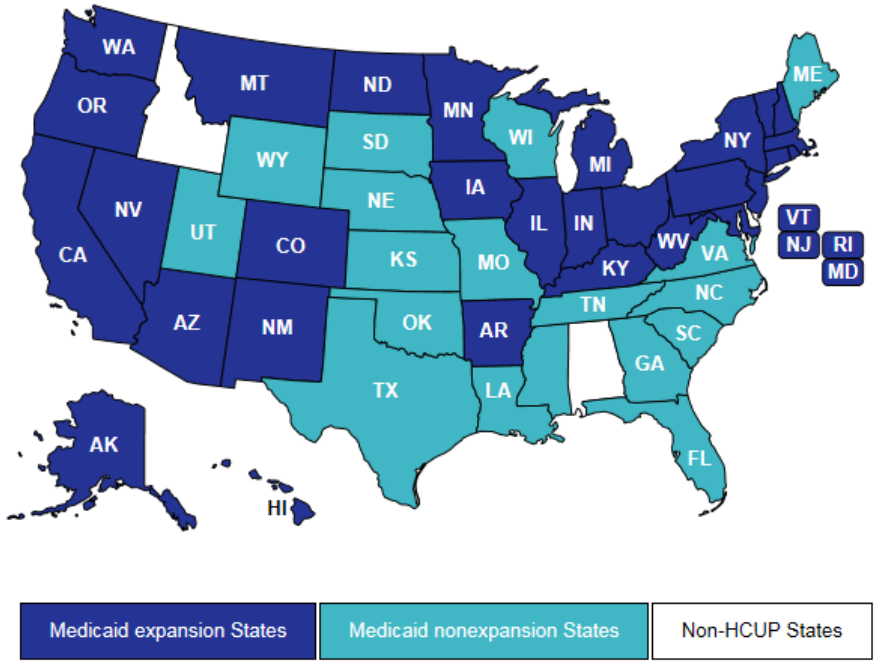
Effect of Medicaid Expansion on Hospital Use

Click map to select one of the identified States, or select from list and click Select: Alaska* Select *Medicaid expansion State

Information is not available for all States.

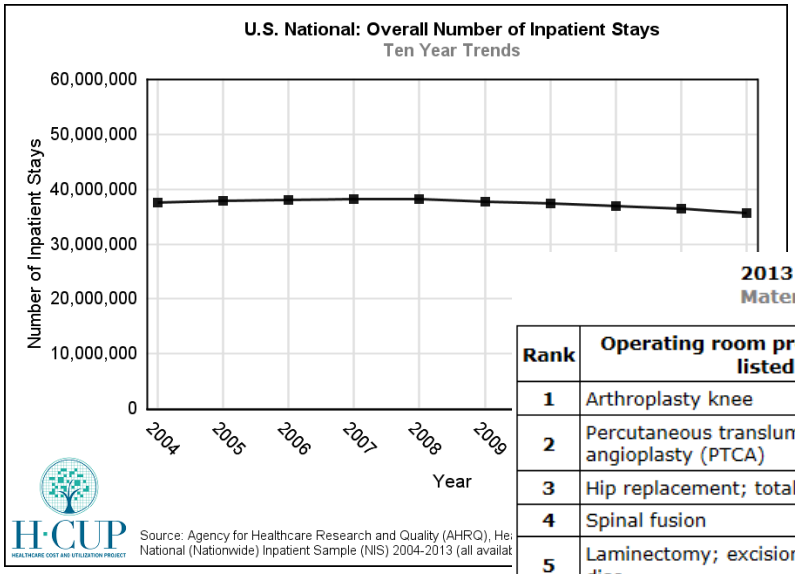
A tutorial for Effect of Medicaid Expansion on Hospital Use is available.

Fast Stats Data Update!



HCUP Fast Stats – *National Hospital Utilization and Costs*

- Includes information on trends in inpatient stays, the most common diagnoses for inpatient stays, and the most common operations during inpatient stays.



2013 U.S. National Inpatient Stays
Maternal/Neonatal Stays Included

Rank	Principal diagnosis	Total number of stays	Rate of stays per 100,000
1	Liveborn	3,764,533	1,196
2	Septicemia (except in labor)	1,297,045	412
3	Osteoarthritis	1,023,070	325
4	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	960,594	305
	ertensive	882,179	280
		835,623	265
		709,560	225
	sease	644,744	205
	r graft	631,960	201
	rperium	625,390	199

ity (AHRQ), Healthcare Cost and Utilization Project

2013 U.S. National Inpatient Stays
Maternal/Neonatal Stays Excluded

Rank	Operating room procedures (all-listed)	Total number of stays	Rate of stays per 100,000
1	Arthroplasty knee	732,550	233
2	Percutaneous transluminal coronary angioplasty (PTCA)	498,975	158
3	Hip replacement; total and partial	493,675	157
4	Spinal fusion	454,550	144
5	Laminectomy; excision intervertebral disc	452,115	144
6	Other OR procedures on vessels other than head and neck	421,995	134
7	Cholecystectomy and common duct exploration	387,980	123
8	Partial excision bone	344,915	110
9	Colorectal resection	302,485	96
10	Excision; lysis peritoneal adhesions	295,020	94

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2013

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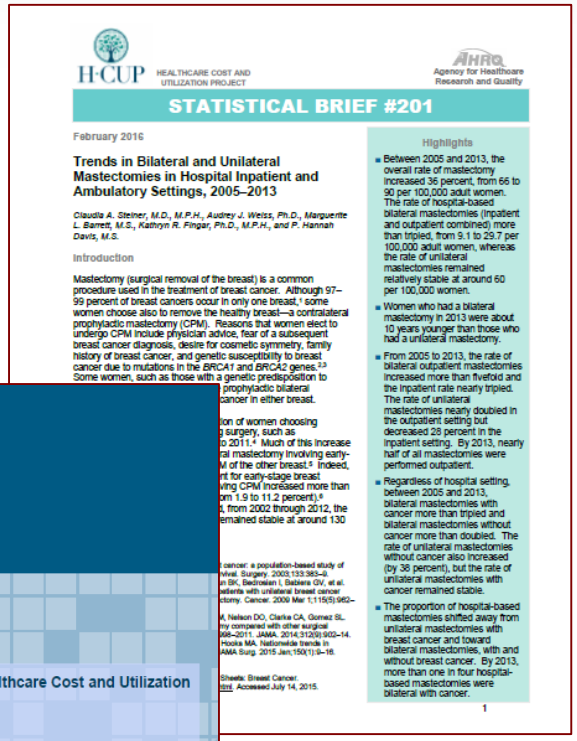
HCUP Publications

- **Statistical Briefs**
- **Methods Series Reports**


H-CUP HEALTHCARE COST AND UTILIZATION PROJECT

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #201

February 2016

Trends in Bilateral and Unilateral Mastectomies in Hospital Inpatient and Ambulatory Settings, 2005–2013

Claudia A. Steiner, M.D., M.P.H., Audrey J. Weiss, Ph.D., Marguerite L. Barrett, M.S., Kathryn R. Fingar, Ph.D., M.P.H., and P. Hannah Davis, M.S.

Introduction

Mastectomy (surgical removal of the breast) is a common procedure used in the treatment of breast cancer. Although 97–99 percent of breast cancers occur in only one breast,[1] some women choose also to remove the healthy breast—a contralateral prophylactic mastectomy (CPM). Reasons that women elect to undergo CPM include physician advice, fear of a subsequent breast cancer diagnosis, desire for cosmetic symmetry, family history of breast cancer, and genetic susceptibility to breast cancer due to mutations in the *BRCA1* and *BRCA2* genes.[2,3] Some women, such as those with a genetic predisposition to

prophylactic bilateral

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M of the other breast.[5] Indeed,

rt for early-stage breast

ving CPM increased more than

om 1.9 to 11.2 percent),[6]

, from 2002 through 2012, the

emained stable at around 130

Highlights

- Between 2005 and 2013, the overall rate of mastectomy increased 36 percent, from 66 to 90 per 100,000 adult women. The rate of hospital-based bilateral mastectomies (inpatient and outpatient combined) more than tripled, from 9.1 to 29.7 per 100,000 adult women, whereas the rate of unilateral mastectomies remained relatively stable at around 60 per 100,000 women.
- Women who had a bilateral mastectomy in 2013 were about 10 years younger than those who had a unilateral mastectomy.
- From 2005 to 2013, the rate of bilateral outpatient mastectomies increased more than fivefold and the inpatient rate nearly tripled. The rate of unilateral mastectomies nearly doubled in the outpatient setting but decreased 28 percent in the inpatient setting. By 2013, nearly half of all mastectomies were performed outpatient.
- Regardless of hospital setting, between 2005 and 2013, bilateral mastectomies with cancer more than tripled and bilateral mastectomies without cancer more than doubled. The rate of unilateral mastectomies without cancer also increased (by 36 percent), but the rate of unilateral mastectomies with cancer remained stable.
- The proportion of hospital-based mastectomies shifted away from unilateral mastectomies with breast cancer and toward bilateral mastectomies, with and without breast cancer. By 2013, more than one in four hospital-based mastectomies were bilateral with cancer.

1

cancer: a population-based study of

Surgery. 2003;133:383–9.

BK, Bedrosian I, Babiera GV, et al.

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tomy. Cancer. 2009 Mar 1;115(5):982–

M, Nelson DO, Clarke CA, Gomez SL.

ny compared with other surgical

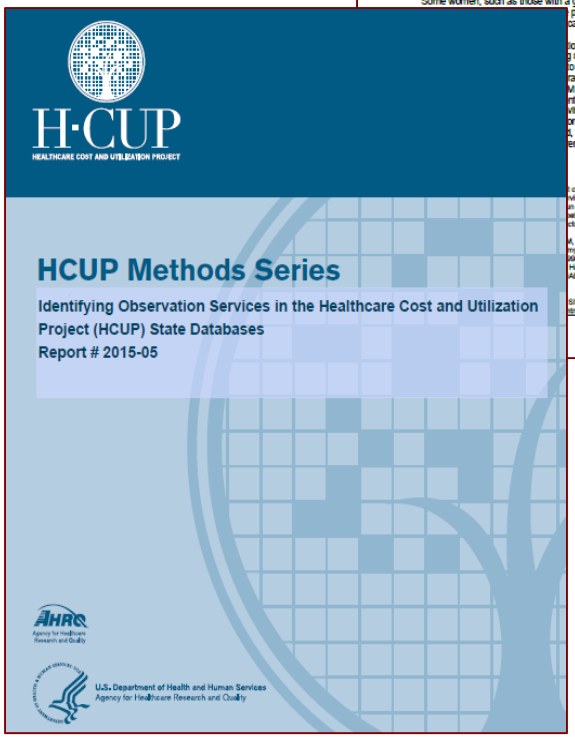
09–2011. JAMA. 2014;312(9):902–14.

Hooks MA. Nationwide trends in

AMA Surg. 2015 Jan;150(1):9–16.

Sheets: Breast Cancer.

html. Accessed July 14, 2015.


H-CUP HEALTHCARE COST AND UTILIZATION PROJECT

HCUP Methods Series

Identifying Observation Services in the Healthcare Cost and Utilization Project (HCUP) State Databases

Report # 2015-05

AHRQ Agency for Healthcare Research and Quality

U.S. Department of Health and Human Services Agency for Healthcare Research and Quality

Statistical Brief Topics

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #202

March 2016

Mental and Substance Use Disorders Among Hospitalized Teenagers, 2012

Kevin C. Heslin, Ph.D., and Anne Elixhauser, Ph.D.

Introduction

Young people are at increased risk for mental and substance use disorders (M/SUDs) because of a number of factors, including rapid physical and emotional changes, family history, home environment, and peer influences.[1,2] In the United States, one in five young people between the ages of 13 and 18 years (21.4 percent) are currently experiencing or have had a seriously debilitating mental disorder at some point in the past.[3] During 2012, 9.1 percent of young people between the ages of 12 and 17 years (about 2.2 million) experienced a major depressive episode—and among these, an estimated 34.0 percent (753,000) also used illicit drugs.[4] Further, epidemiologic surveys of adults suggest that substance use among young people frequently continues and worsens into adulthood. For example, the prevalence of alcohol use disorders is consistently higher among adults who initiated use by age 14 years than among those who first used at age 18 years or older.[5] Thus, effective prevention, treatment, and recovery support services targeting young people with M/SUDs represent a critical opportunity not only to improve functioning and well-being in the short term but also to affect the life course trajectories of emerging adults.

The delivery and financing of M/SUD care for young people have undergone tremendous changes in the past 30 years in

Highlights

- In 2012, 310,100 community hospital stays among teenagers (ages 13 to 19 years) included at least one mental or substance use disorder diagnosis; more than one-fo stays in this age g percent).
- Females made up stays with mental but only 35.7 perc substance use dis 44.7 percent with mental and substa disorders.
- Mood disorders w common mental d stays), followed b disorders (85,800 attention and cond (81,700 stays).
- The rate of stays and conduct disor percent lower for for 13-year-olds (stays per 100,000 year-olds: 261 sta population).
- Cannabis use dis most common sut disorder (54,100 alcohol use disord stays) and opioid (14,500 stays).
- The rate of stays use disorders was times higher amo than among 13-ye olds: 137 stays pe population; 13-ye per 100,000 popu

[1] Hesselbrock VM, Hesselbrock MN. Developmental perspectives on the risk for developing substance abuse problems. In: WR Miller & KM Carroll (Eds.), Rethinking Substance Abuse: What the Science Shows, and What We Should Do About It. New York: Guilford Press; 2010:97–114.
[2] Merikangas KR, Nakamura EF, Kessler RC. Epidemiology of mental disorders in children and adolescents. Dialogues in Clinical Neuroscience. 2009;11(1):7–20.
[3] National Institute of Mental Health. Statistics: Any Disorder Among Children. http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml. Accessed January 25, 2016.
[4] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. 2013 National Survey on Drug Use and Health: Mental Health Detailed Tables. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. http://www.samhsa.gov/data/sites/default/files/2013MHDetTabs/NSDUH-MHDetTabs2013.pdf. Accessed January 25, 2016.
[5] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qua the 2013 National Survey on Drug Use and Health: Summary of National Findings. HHS Publication No. (SMA) MD: Substance Abuse and Mental Health Services Administration; 2014. http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf. A 2016.

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

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STATISTICAL BRIEF #201

February 2016

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Claudia A. Steiner, M.D., M.P.H., Audrey J. Weiss, Ph.D., Marguerite L. Barrett, M.S., Kathryn R. Fingar, Ph.D., M.P.H., and P. Hannah Davis, M.S.

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Research indicates that the proportion of women choosing mastectomy over breast-conserving surgery, such as lumpectomy, increased from 1998 to 2011.[4] Much of this increase is attributed to an increase in bilateral mastectomy involving early-stage cancer in one breast and CPM of the other breast.[5] Indeed, among women undergoing treatment for early-stage breast cancer, the percentage of those having CPM increased more than fivefold between 1998 and 2011 (from 1.9 to 11.2 percent).[6] During this approximate time period, from 2002 through 2012, the incidence of breast cancer overall remained stable at around 130 per 100,000 women.[7]

Highlights

- Between 2005 and 2013, the overall rate of mastectomy increased 36 percent, from 66 to 90 per 100,000 adult women. The rate of hospital-based bilateral mastectomies (inpatient and outpatient combined) more than tripled, from 9.1 to 29.7 per 100,000 adult women, whereas the rate of unilateral mastectomies remained relatively stable at around 60 per 100,000 women.
- Women who had a bilateral mastectomy in 2013 were about 10 years younger than those who had a unilateral mastectomy.
- From 2005 to 2013, the rate of bilateral outpatient mastectomies increased more than fivefold and the inpatient rate nearly tripled. The rate of unilateral mastectomies nearly doubled in the outpatient setting but decreased 28 percent in the inpatient setting. By 2013, nearly half of all mastectomies were performed outpatient.
- Regardless of hospital setting, between 2005 and 2013, bilateral mastectomies with cancer more than tripled and bilateral mastectomies without cancer more than doubled. The rate of unilateral mastectomies without cancer also increased (by 38 percent), but the rate of unilateral mastectomies with cancer remained stable.
- The proportion of hospital-based mastectomies shifted away from unilateral mastectomies with breast cancer and toward bilateral mastectomies, with and without breast cancer. By 2013, more than one in four hospital-based mastectomies were bilateral with cancer.

[1] Poledniak AP. Bilateral synchronous breast cancer: a population-based study of characteristics, method of detection, and survival. Surgery. 2003;133:383–9.
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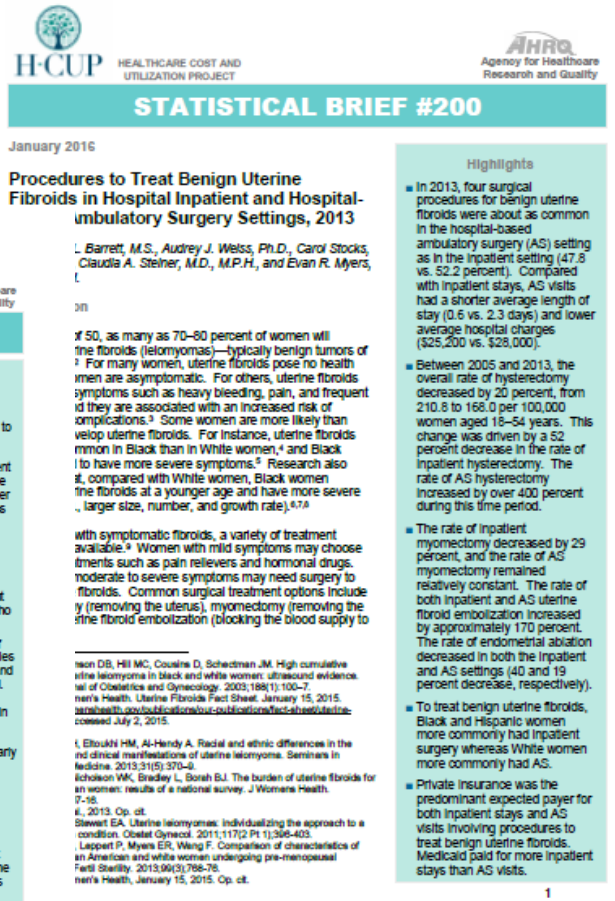
[3] Kurian AW, Lichtensztajn DY, Keegan THM, Nelson DO, Clarke CA, Gomez SL. Use of and mortality after bilateral mastectomy compared with other surgical treatments for breast cancer in California, 1998–2011. JAMA. 2014;312(9):902–14.
[4] Kummerow KL, Du L, Penson DF, Shyr Y, Hooks MA. Nationwide trends in mastectomy for early-stage breast cancer. JAMA Surg. 2015 Jan;150(1):9–16.
[5] Ibid.
[6] Ibid.
[7] National Cancer Institute. SEER Stat Fact Sheets: Breast Cancer. http://seer.cancer.gov/statfacts/html/breast.html. Accessed July 14, 2015.



H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #200

January 2016

Procedures to Treat Benign Uterine Fibroids in Hospital Inpatient and Hospital-ambulatory Surgery Settings, 2013

L. Barrett, M.S., Audrey J. Weiss, Ph.D., Carol Stocks, Claudia A. Steiner, M.D., M.P.H., and Evan R. Myers, I.

on

f 50, as many as 70–80 percent of women will ine fibroids (leiomyomas)—typically benign tumors of . For many women, uterine fibroids pose no health men are asymptomatic. For others, uterine fibroids symptoms such as heavy bleeding, pain, and frequent d they are associated with an increased risk of omplications.[3] Some women are more likely than velop uterine fibroids. For instance, uterine fibroids mmon in Black than in White women,[4] and Black l to have more severe symptoms.[5] Research also t, compared with White women, Black women ine fibroids at a younger age and have more severe ., larger size, number, and growth rate).[6,7,8]

with symptomatic fibroids, a variety of treatment available.[9] Women with mild symptoms may choose tments such as pain relievers and hormonal drugs. moderate to severe symptoms may need surgery to fibroids. Common surgical treatment options include y (removing the uterus), myomectomy (removing the ine fibroid embolization (blocking the blood supply to

Highlights

- In 2013, four surgical procedures for benign uterine fibroids were about as common in the hospital-based ambulatory surgery (AS) setting as in the inpatient setting (47.8 vs. 52.2 percent). Compared with inpatient stays, AS visits had a shorter average length of stay (0.6 vs. 2.3 days) and lower average hospital charges ($25,200 vs. $28,000).
- Between 2005 and 2013, the overall rate of hysterectomy decreased by 20 percent, from 210.8 to 168.0 per 100,000 women aged 18–54 years. This change was driven by a 52 percent decrease in the rate of inpatient hysterectomy. The rate of AS hysterectomy increased by over 400 percent during this time period.
- The rate of inpatient myomectomy decreased by 29 percent, and the rate of AS myomectomy remained relatively constant. The rate of both inpatient and AS uterine fibroid embolization increased by approximately 170 percent. The rate of endometrial ablation decreased in both the inpatient and AS settings (40 and 19 percent decrease, respectively).
- To treat benign uterine fibroids, Black and Hispanic women more commonly had inpatient surgery whereas White women more commonly had AS.
- Private insurance was the predominant expected payer for both inpatient stays and AS visits involving procedures to treat benign uterine fibroids. Medicaid paid for more inpatient stays than AS visits.

[1] Barrett, M.S., Audrey J. Weiss, Ph.D., Carol Stocks, Claudia A. Steiner, M.D., M.P.H., and Evan R. Myers, I.

nson DB, Hill MC, Cousins D, Schectman JM. High cumulative rine leiomyoma in black and white women: ultrasound evidence. ial of Obstetrics and Gynecology. 2003;188(1):100–7.
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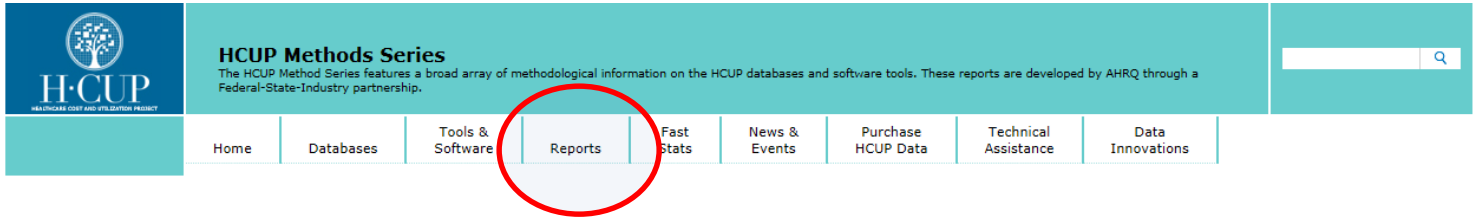
, Leppert P, Myers ER, Wang F. Comparison of characteristics of an American and white women undergoing pre-menopausal Fertil Sterility. 2013;99(3):768–76.
nen's Health, January 15, 2015. Op. cit.

HCUP Methods Reports

Methodological information on the HCUP databases and software tools



HCUP Methods Series

The HCUP Methods Series features a broad array of methodological information on the HCUP databases and software tools. Reports in the series are listed below by category. Reports are also listed by year in chronological order.

Methodology
- Calculating Costs
- Diagnosis Present-on-Admission Indicators
- Estimating Trends (NIS and KID)
- Expected Payer
- Observation Services
- Population Denominator Data for Use with HCUP Databases
- Readmission and Revisit Analyses
- Statistical Methods

HCUP Methods for NHQR and NHDR
- NHDR
- NHQR

Comparison Reports
- NIS
- KID

Evaluations of Data
- Emergency Department Data
- State Ambulatory Surgery and Services Databases
- Other (Patient Safety Variation, E Codes, Observation Stays)

Enhancing Administrative Data
- Clinical Information
- Synthetic Person Numbers (for linking across settings and over time)

HCUP Tool Development
- Clinical Classifications Software
- Comorbidity Software
- Utilization Flags

Calculating Costs

Report #2011-04	Tools for More Accurate Inpatient Cost Estimates with HCUP Databases, 2009 (PDF file, 837 KB)
Report #2008-04	Calculate Cost Adjustment Factors by APR-DRG and CCS Using Selected States with Detailed Charge (PDF file, 122 KB)
Report #2008-03	The Cost of Ambulatory Surgery Visits, 2005 (PDF file, 187 KB)
Report #2007-05	The Cost of "Treat and Release" to Hospital Emergency Departments, 2003 (PDF file, 166 KB)

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Reports

HCUP reports include new findings, publications, research notes based on HCUP data, and technical reports about HCUP issues. These products are developed by AHRQ through a Federal-State-Industry partnership.

Favorites

CUP Statistical Briefs

atistical Briefs are simple, descriptive reports on a riety of specific health-care related issues. A full list is ailable by topic and chronological order. The most recent efs are:

- Mental and Substance Use Disorders Among Hospitalized Teenagers, 2012
- Trends in Bilateral and Unilateral Mastectomies in Hospital Inpatient and Ambulatory Settings, 2005-2013

HCUP Infographics

Infographics provide a visual representation of Statistical Brief data. A full list is available. The most recent infographic is:

- Neonatal and Maternal Hospital Stays Related to Substance Use, 2006-2012 (PDF file, 257 KB)

HCUP Projections

Projection reports use longitudinal HCUP data to project national and regional estimates on health care priorities. A full list is available. The most recent reports are:

- Acute Myocardial Infarction (AMI) and Acute Stroke 2004 to 2015 (PDF file, 3.2 MB)
- *Clostridium Difficile* Hospitalizations 2003-2015 (PDF file, 1.9 MB)

Information About Using HCUP Data

CUP Methods Series

ethods Series reports, organized by topic and ronological order, feature a broad array of ethodological information on the HCUP databases and ftware tools. The most recent reports are:

- Calculating National Inpatient Sample (NIS) Variances for Data Years 2012 and Later (PDF file, 565 KB)
- User Guide - An Examination of Expected Payer Coding in HCUP Databases (PDF file, 542 KB) Supplements 1-3 (PDF file, 880 KB)

HCUP Nationwide Database Reports

These reports are specific to the design and content of the HCUP nationwide databases.

- National (Nationwide) Inpatient Sample (NIS)
- Kids' Inpatient Database (KID)
- Nationwide Emergency Department Sample (NEDS)

HCUP State Database Reports

These reports are specific to the design and content of the HCUP state databases.

- State Inpatient Databases (SID)
- State Ambulatory Surgery and Services Databases (SASD)
- State Emergency Department Databases (SEDD)

Publications and Additional Topics

pical Reports

pical reports provide information about various priority pulations.

- Approaches to using race-ethnicity data for reducing disparities
- Utilization and spending for mental and substance use disorders

HCUP Publications

These links provide access to lists of publications, resources, and descriptions of research activities that are based on HCUP data, software products, and tools.

- Search for HCUP publications
- Research Spotlights on recent peer-reviewed journal articles
- Review comprehensive list of AHRQ publications

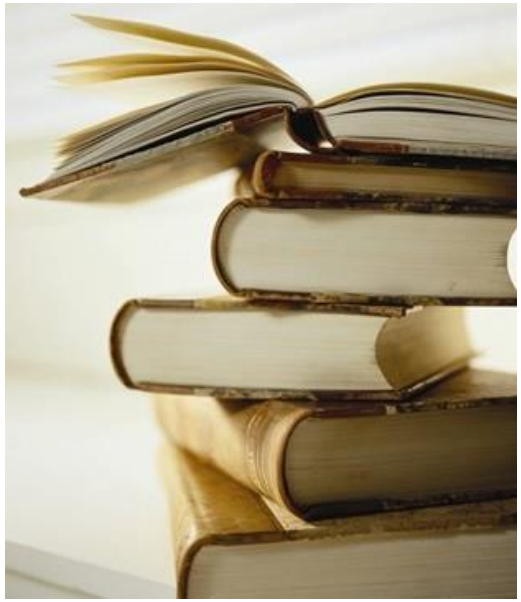
HCUP Archive

This archive features a broad array of information based on HCUP databases and other related reports.

- The Value of Hospital Discharge Data (PDF file, 664 KB) (Posted May 2005)
- HCUP Facts and Figures (2005-2009)
- HCUP Highlights (2001-2003)
- HCUP Fact Books (1997-2004)
- HCUP National Statistics Archive (1992-1996)

New: Publications Search Page on HCUP-US

- **Simple or advanced search options**
  - Data Year
  - Database, Tool, & Product
  - Author
  - Title
  - State



HCUP Supports High Impact Health Services, Policy & Clinical Research

Using HCUP Tools in Research

- **Research Spotlights**
  - http://www.hcup-us.ahrq.gov/reports/spotlights.jsp

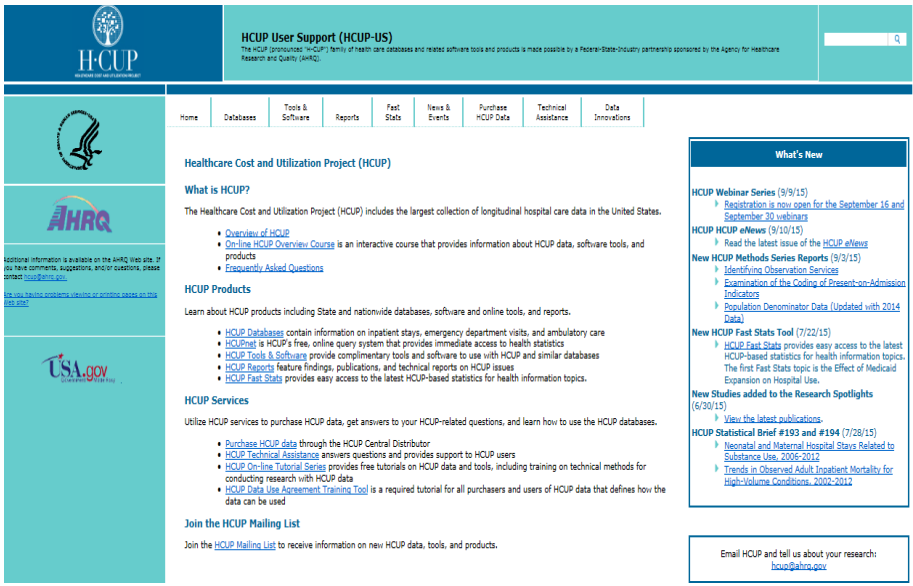
Bartlett, EK, Simmons, KD, Wachtel, H, Roses, RE, Fraker, DL, Kelz, RR, Jarakousis, GC. The rise in metastasectomy across cancer types over the past decade. *Cancer.* 2015 Marc 1;121(5):747-57.

Webinar Overview

- Brief Database Review
- Tools & Software
- Supplemental Files
- HCUPnet Overview
- HCUP Fast Stats
- Publications and Publication Search
- How to Access HCUP Resources

HCUP User Support Web Site

- **Find detailed information on HCUP databases, tools, and products**
- **Access HCUPnet**
- **Find comprehensive list of HCUP-related publications, HCUP Statistical Briefs, and database reports**
- **Access technical assistance**



http://www.hcup-us.ahrq.gov

HCUP Technical Assistance

Active Technical Assistance

- Responds to inquiries about HCUP data, products, and tools
- Collects user feedback and suggestions for improvement

E-mail: hcup@ahrq.gov

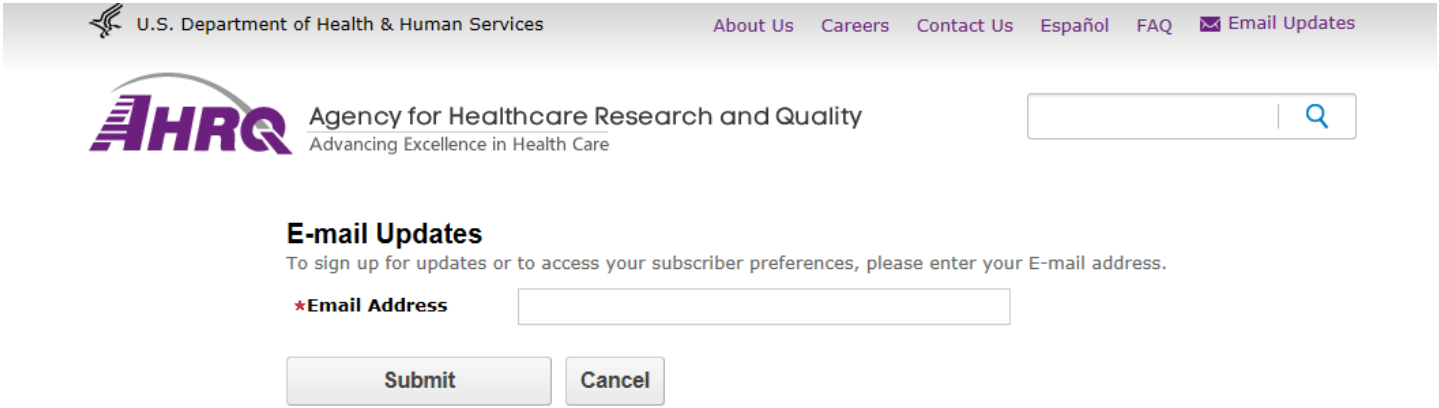
Interactive Online HCUP Tutorials &Training Courses

- HCUP Overview
- Load and Check HCUP Data
- **Nationwide Readmissions Database (NRD)** NEW!
- HCUP Sample Designs
- Produce National HCUP Estimates
- Calculate Standard Errors
- Multi-Year Analysis

National Estimates and Multi-Year Analysis Tutorials have been updated to reflect changes in the 2012 NIS redesign

Join the HCUP Email List

- HCUP Newsletter, published quarterly
  - User Tech Tips
  - Upcoming Events
- New Data Releases
- New Reports



https://subscriptions.ahrq.gov/accounts/USAHRQ/subscriber/new?topic_id=USAHRQ_65

Healthcare Cost and Utilization Project (HCUP)

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HEALTHCARE COST AND UTILIZATION PROJECT

Questions/Comments?

Time for Questions and/or Comments.

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